HUNTERIAN SOCIETY

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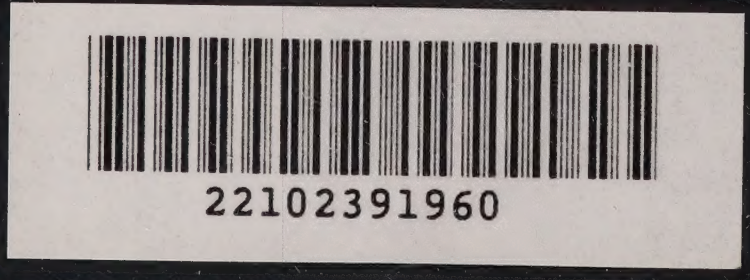
SESSION 1896-97.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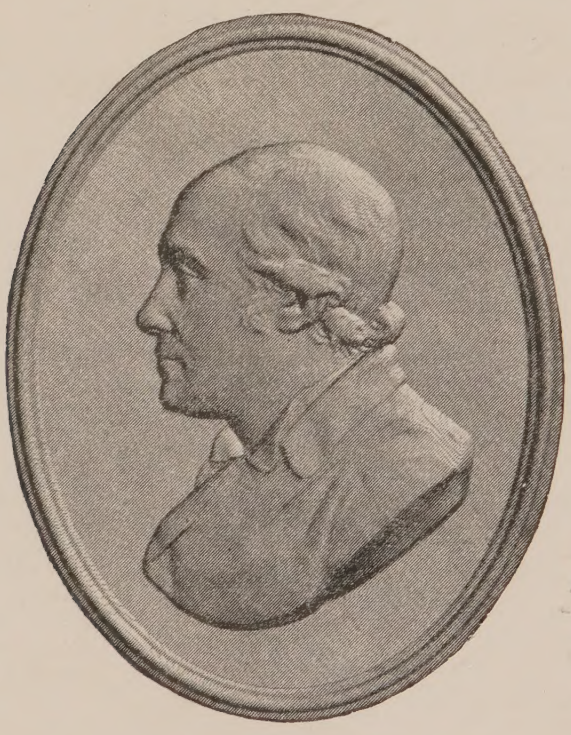
1896-97.

SEVENTY-EIGHTH SESSION.



COLLEGE OF PHYSICIANS
CANCELLED

Ratio Societatis Vinculum.

LONDON:
HEADLEY BROTHERS, 14, BISHOPSGATE WITHOUT, E.C.,
AND ASHFORD, KENT.

1897.

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PRESIDENTS OF THE SOCIETY

FROM ITS INSTITUTION.

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1822 Benjamin Robinson, M.D.
1824 William Babington, M.D., F.R.S.
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1830 Thomas Callaway.
1832 Charles Aston Key.
1834 Benjamin Guy Babington, M.D., F.R.S.
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1838 John Whiting, M.D.
1839 John Scott.
1841 William Cooke, M.D.
1843 James Luke.
1845 Richard Bright, M.D., F.R.S.
1847 G. W. Macmurdo, F.R.S.
1848 Francis Henry Ramsbotham, M.D.
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1860 Sir James Risdon Bennett, M.D., F.R.S.
1861 George Critchett.
1863 Thomas Mee Daldy, M.D.
1865 Alfred Smee, F.R.S.
1866 Stephen Henry Ward, M.D.
1867 John Jackson.
1868 Thomas Bevill Peacock, M.D.
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1872 Herbert Davies, M.D.
1873 Thomas Bryant, M.Ch.
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1888 R. Clement Lucas, B.S., M.B.
1890 Stephen Mackenzie, M.D.
1892 Frederick Gordon Brown.
1894 Charters J. Symonds, M.S., M.D.
1896 G. Ernest Herman, M.B.

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OF THE

HUNTERIAN SOCIETY

ELECTED FEBRUARY, 1896.

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G. Ernest Herman, M.D.

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Arthur T. Davies, M.D.

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Librarian.

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Fred. J. Smith, M.D.
A. H. Tubby, M.S.

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T. H. Arnold Chaplin, M.D.
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Hope Grant, F.R.C.S.E.
Thomas Glover Lyon, M.D.
John W. Oliver, M.D.
William Rawes, M.B.
Henry J. Sequeira.
St. Clair B. Shadwell, M.D.
Charters J. Symonds, M.S.
Jas. H. Targett, M.S.
John F. Woods, M.D.

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Hope Grant, F.R.C.S.E.
Francis R. Humphreys.
Thomas Glover Lyon, M.D.

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(Appointed by the Council.)

John W. Oliver, M.D.
R. Hingston Fox, M.D.
T. Glover Lyon, M.D.
Henry J. Sequeira.

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LORD LISTER, D.C.L., LL.D., F.R.S., Surgeon Extraordinary to H.M. the Queen, *12, Park Crescent, Portland Place, W.*

SIR JAMES PAGET, Bart., D.C.L., LL.D., F.R.S., Sergeant-Surgeon to H.M. the Queen ; Surgeon-in-Ordinary to H.R.H. the Prince of Wales, *5, Park Square West, Regent's Park, N.W.*

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SAMUEL GROSS, M.D., LL.D., Professor of Surgery in the Jefferson Medical College, Philadelphia.

RUDOLPH VIRCHOW, M.D., LL.D., Professor of Pathological Anatomy in the University of Berlin.

LIFE FELLOWS.

P., President; V.P., Vice-President; C., Council; O., Orator; S., Secretary; T., Treasurer; L., Librarian; Aud., Auditor.

C.* This indicates that *more* than two years have been served on the Council.

A. By payment of twenty-five Annual Subscriptions, in accordance with Law LXIII.

When Admitted.

1856 ALLINGHAM, WILLIAM, F.R.C.S., late Senior Surgeon to St. Mark's Hospital, *25, Grosvenor Street, W.* ; V.P. 1869-70, C.* 1861-2, S. 1865-6-7-8.

1864 BADER, CHARLES, Consulting Ophthalmic Surgeon to Guy's Hospital, *10, Finsbury Circus, E.C.* ; C 1870.

1854 BARNES, ROBERT, M.D., Consulting Obstetric Physician to St. George's Hospital . . . *Lingwood, Liss, Hants.* ; P 1874, V.P. 1864-5, O. 1863, C.* 1859-62.

1860 BERRY, HENRY T. . . . *66, Pembridge Villas, Bayswater, W.* ; V.P. 1874, C. 1871-2.

1865 BROWN, FREDERICK GORDON . *17, Finsbury Circus, E.C.* ; P. 1892-3, V.P. 1881-2, C.* 1869-70, S. 1872 to 1876, Aud. 1895.

1862 BRYANT, THOMAS, F.R.C.S., Consulting Surgeon to Guy's Hospital, *65, Grosvenor Street, W.* ; P. 1873, V.P. 1870-1, O. 1870, C.* 1866-7.

1871 BUNCOMBE, CHAS. H., F.R.C.S. . *35, Montserrat Road, Putney* ; C. 1886-7.

1858 CLAPTON, EDWARD, M.D., F.R.C.S., late Physician to St. Thomas's Hospital, *22, St. Thomas Street, S.E., and Towercroft, Lee, S.E.* ; V.P. 1872-3, 1875, C.* 1870-1.

1858 CORNER, FRANCIS M., Trustee . *Manor House, Poplar, E.* ; P. 1886, V.P. 1868-9, 1880-1, C.* 1862, 1864.

When Admitted.

1862 COUPER, JOHN, M.D., F.R.C.S., Consulting Surgeon to the London Hospital . . . *80, Grosvenor Street, W.*; P. 1880, V.P. 1873-4, O. 1874, C. 1867, 1881.

1854 CROSBY, THOMAS B., M.D., F.R.C.S., *19, Gordon Square, W.C., and 13, Fenchurch Street, E.C.*; P. 1878. V.P. 1866-7, O. 1871, C.* 1860-1.

1854 FOTHERBY, HENRY I., M.D., Trustee, Consulting Physician to the Metropolitan Hospital . *Woodthorpe Cote, Wray Common, Reigate, Surrey*; P. 1876, V.P. 1868-9, O. 1869, C.* 1871-2, S. 1857 to 1867.

1863 GREENWOOD, JAMES, M.D. . *48, Canonbury Square, Islington, N.*; V.P. 1880-1, C.* 1873-4.

1862 GREENWOOD, MAJOR, M.D. . *26, Queen's Road, Dalston, N.*; V.P. 1884-5, C.* 1872-3.

1862 HICKS, G. BORLASE . . . *149, Amhurst Road, Hackney, N.E.*; V.P. 1888-9-90, C. 1886-7.

1860 HICKS, JOHN BRAXTON, M.D., F.R.S., Consulting Obstetric Physician to Guy's and St. Mary's Hospitals, *The Brackens, Lymington, Hants*; P. 1879, V.P. 1869-70, O. 1868, C.* 1864-5.

1855 HUTCHINSON, JONATHAN, F.R.C.S., LL.D., F.R.S., Consulting Surgeon to the London Hospital, *15, Cavendish Square, W.*; P. 1869-70; V.P. 1863-4, O. 1865, C.* 1860, 1862.

1862 JACKSON, J. HUGHLINGS, M.D., F.R.S., Consulting Physician to the London Hospital . . *3, Manchester Square, W.*; P. 1882. V.P. 1870-1, O. 1872, C. 1866, 1883.

1860 LICHTENBERG, GEO., M.D., Surgeon to the German Hospital, *47, Finsbury Square, E.C.*; V.P. 1878-9, C.* 1864-5.

1869 MCCARTHY, JEREMIAH, M.A., F.R.C.S., Surgeon to the London Hospital . . . *1, Cambridge Place, Victoria Road, Kensington*; V. P. 1877-8, C.* 1874-5.

1850 MILLER, CLAUDIUS M., M.D. . *100, Stoke Newington Road, N.*; V.P. 1863-4, C.* 1855, 1860.

1841 MUNK, WILLIAM, M.D. . . *40, Finsbury Square, E.C.*; V.P. 1852-3, O. 1858, C.* 1847-8, L. 1844-5-6.

1837 OLDHAM, HENRY, M.D., Consulting Obstetric Physician to Guy's Hospital . . . *4, Cavendish Place, W.*

1864 PETTIFER, EDMUND H. . . *50, Southgate Road, N.*

1870 PYE-SMITH, P. H., M.D., F.R.S., Senior Physician to Guy's Hospital, *48, Brook Street, W.*; P. 1885, V.P. 1879-80, O. 1879, C.* 1875-6.

1855 ROPER, GEORGE, M.D. . . *Oulton Lodge, Aylsham, Norfolk*; V.P. 1879-80, O. 1883, C.* 1860, 1876.

1853 SAUNDERS, W. SEDGWICK, M.D., F.S.A., *13, Queen Street, Cheapside, E.C.*; P. 1875, V.P. 1864-5, O. 1867, C.* 1858, 1860.

1842 SEWELL, CHARLES BRODIE, M.D. *Tintoch House, Barton Fields, Canterbury*; C. 1848.

When Admitted.

1869 SMEE, ALF. H. . . . *The Grange, Hackbridge, Surrey*; V.P. 1889-90, O. 1881, C.* 1875-6.

1875 STEVENS, G. J. B. . . . *Wadhurst House, Stoke Newington Green, N.*; V.P. 1887-88, C. 1878-79, and 1896.

1869 TAY, WAREN, F.R.C.S., Senior Surgeon to the London Hospital, *4, Finsbury Square, E.C.*; V.P. 1882-3, C. 1876-9, S. 1873-4-5 and 1888-9-90.

B. By purchase, in accordance with Law LXII.

1892 BEEVOR, SIR HUGH, Bart., M.D., *18, Sergeant's Inn, Fleet Street, E.C.*; C. 1895-97.

1865 BROWNFIELD, MATTHEW, M.D. . *171, East India Road, E.*; V.P. 1882-3, C.* 1869-70.

1864 CLAPTON, WILLIAM, F.R.C.S. . *27, Queen Street, Cheapside, E.C.*; V.P. 1885-6, C.* 1869-70.

1879 DAVIES, JOHN, M.D. . . *91, New North Road, N.*; C. 1889.

1863 GERVIS, HENRY, M.D. . . *40, Harley Street, W.*; P. 1887, V.P. 1875-6, O. 1875, C. 1867.

1876 GILBERT, EDWARD G., M.D. . *3, Culverden Gardens, Tunbridge Wells.*

1875 HERMAN, GEO. ERNEST, M.B., F.R.C.S., President, *20, Harley Street, W.*; P. 1896-7, V.P. 1887, O. 1888, C.* 1879-80, S. 1881-2-3-4.

1883 HOVELL, T. MARK, F.R.C.S. . *105, Harley Street, W.*; V.P. 1895-6, C.* 1887, 1889.

1863 LITTLE, LOUIS S., F.R.C.S. . *Bletchingly, Surrey*; C. 1868.

1874 LUCAS, R. CLEMENT, M.B., B.S. *50, Wimpole Street, W.*; P. 1888-9, V.P. 1883-4, O. 1887, C. 1891-4, S. 1876-7-8-9-80-1-2, Aud. 1892-3-4.

1876 MACKENZIE, STEPHEN, M.D., F.R.C.P., late President, Senior Physician to the London Hospital . *18, Cavendish Sq., W.*; P. 1889-90, V.P. 1884-5, O. 1889, C. 1880-1, S. 1877-8-9.

1881 POLAND, JOHN, F.R.C.S. . . *4, St. Thomas's Street, Boro.', S.E.*; V.P. 1893-4, S. 1887-8-9-90-1-2.

1875 PORT, HEINRICH, M.D., Physician to the German Hospital, *48, Finsbury Sq., E.C.*; V.P. 1888-9, C.* 1880-1.

1877 TURNER, F. CHARLEWOOD, M.D., Treasurer, Physician to the London Hospital . . . *15, Finsbury Square, E.C.*; V.P. 1890-1, O. 1884, C. 1881-1883, S. 1885 to 1889, T. 1891 to 1897.

1857 WALLACE, RICHARD U., M.B. . *148, Stamford Hill, N.*; V.P. 1873-4-5, C. 1870.

ORDINARY FELLOWS.

When Admitted.

1893 ADAMS, JOHN, F.R.C.S. . *180, Aldersgate Street, E.C.*

1896 AGAR, MORLEY F. . . . *11, Wimpole St. Cavendish Sq., W., Ponders End.*

1884 APPLEFORD, STEPHEN H., M.D. *17, Finsbury Circus, E.C.*; V.P. 1897, C.* 1888-9, Aud. 1893-4.

When Admitted.

1889 Barlow, Thos. C. . . . *88, Dalston Lane, N.E.*
1897 Barnard, H. L., F.R.C.S., . *36, Hamilton Rd., Highbury, N.*
1875 Beach, Fletcher, M.B. . *64, Welbeck St., Cavendish Square, W., and Winchester House, Kingston Hill, Surrey*, V.P. 1888-9, O. 1890, C. 1878-9.
1893 Berrill, Alfred . . . *Waveney House, High Road, South Woodford, Essex.*
1875 Blewitt, Byron . . . *12, St. Mary Axe, E.C.*
1876 Bowkett, Thos. E., . . *145, East India Dock Road, E.;* V.P. 1892-3, C.* 1882, 1887.
1888 Bredin, J. Noble, . . . *Linden Lodge, Potton, Beds.*
1883 Brown, T. Lloyd, . . . *24, Prah Road, Finsbury Park, N.;* C.* 1889-90.
1892 Burgess, Edward, A. . . *Travelling.*
1897 Burgess, C. Venning . . *233, Gt. Dover Street, S.E.*
1896 Burrows, C. W. G. . . *Weston House, 175, Long Lane, S.E.*
1896 Byrne, Benjamin . . . *20, Stainsby Road, Poplar, E.*
1896 Campbell, H. J., M.D. . . *36, Manningham Lane, Bradford, Yorks.*
1889 Cattell, G. Trew, M.D. . . *30, Hereford Sq., South Kensington, S.W.*
1892 Chaplin, T. H. Arnold, B.A., M.D., *24, Finsbury Circus, E.C.;* C. 1895, L. 1897.
1890 Corner, M. Cursham . . *113, Mile End Road, E.*
1882 Cotman, J. S. E. . . . *141, Minories, E.;* V.P. 1894-5, C.* 1887-8, O. 1892, Aud. 1890-1.
1889 Cressy, A. Z. Claydon . . *Hayesden, Wallington, Surrey.*
1896 Crosse, William H. . . *45, Dover Street, Piccadilly, W.*
1885 Davies, Arthur T., B.A., M.D., *23, Finsbury Sq., E.C.;* V.P. 1896, L. 1888 to 1895, S. 1897.
1895 Davies, Morgan, M.D. . . *10, Goring Street, Houndsditch, E.C.*
1893 Dawson, Bertrand E., M.D., B.Sc., *64, Harley Street, W.;* C. 1896.
1895 Dean, H. P., M.B , M.S. . . *84, Wimpole Street, W.*
1892 Dingle, William A., M.D. . *46, Finsbury Square, E.C.*
1896 Downes, J. Lockhart, M.B., C.M., *271, Romford Road, E.*
1889 Dunn, Louis A., M.B., M.S., . *The College, Guy's Hospital, S.E.;* C. 1895, 1897.
1892 Ettles, W. J. McCulloch, M.D., C.M., *141, Minories, E.C.;* C. 1896.
1877 Forbes, Daniel M. . . . *204, Hoxton Street, N.*
1896 Fordham, J. W. . . . *78, Mile End Road, E.*
1885 Fox, R. Hingston, M.D. . . *23, Finsbury Sq., E.C.;* V.P. 1895-7, O. 1896, C. 1889, S. 1891 to 1894.
1894 Fox, Fortescue, M.D. . . *53, Harley St., W., and Strathpeffer, N.B.*, C. 1897.
1897 Fulton, Henry . . . *Idehurst, Sevenoaks.*
1894 Fyffe, W. Kingston, B.A., M.D., *New Zealand.*
1875 Galabin, Alfred L., M.A., M.D., *49, Wimpole Street, W.;* V.P. 1883-4, O. 1886, C. 1878-9.
1888 Galloway, A. Wilton . . *79, New North Road, N.*
1891 Galloway, James, M.A., M.D., C.M., *21, Queen Anne Street, W.;* C. 1894.
1893 Godding, James . . . *69, East India Dock Road, E.*

When Admitted.

1895 GOODALL, EDWARD W., M.D., B.S. Lond., *Medical Superintendent, Eastern Hospital, Homerton, N.E.*

1877 GOODSALL, DAVID H., F.R.C.S. . *17, Devonshire Place, Upper Wimpole Street, W.*

1875 GRANT, ALEXANDER, M.A., M.D., *370, Commercial Road East, E.*; C. 1882.

1891 GRANT, HOPE, F.R.C.S.E. . *22, City Road, E.C.*; C.* 1894-5.

1877 GRANT, J. DUNDAS, M.A., M.D., C.M., *8, Upper Wimpole Street, W.*; V.P. 1892-3, O. 1893, C.* 1885, 1888, Aud. 1891.

1887 GRANT, LEONARD, M.D. . . *Hillside, Station Rd., New Southgate, N.*

1896 GRIFFIN, J. J., M.D. . . *Waterloo Villa, Greengate, Plaistow, E.*

1893 GROGONO, WALTER A. . . *Berwick House, Broadway, and 216, High Street, Stratford, E.*

1894 HALLEN, A. E. H. CORNELIUS, M.B., C.M., *264, Burdett Road, E.*

1896 HARRIS, A. BUTLER, M.A., M.D. *The Shrubbery, Loughton, Essex.*

1894 HASLETT, W. J. HANDFIELD . *Medical Superintendent, Halliford House Asylum, Sunbury-on-Thames.*

1892 HAWKES, LEWIS A., M.D., C.M. *4, Claremont Square, Pentonville, N.*

1896 HEAD, HENRY, M.D. . . *61, Wimpole Street, W.*

1888 HEWER, J. LANGTON, M.D., B.S. *33, Highbury New Park, N.*; C. 1891-2.

1897 HICKMAN, H. V., M.B. . . *Overton House, The Mall, Wanstead, N.E.*

1896 HILL, JAMES WRIGHT, M.B. . *"Ardlui," N. Woolwich, E.*

1896 HORROCKS, HERBERT, M.D. . *Brompton Hospital, S.W.*

1883 HORROCKS, PETER, M.D. . . *45, Brook Street, Grosvenor Square, W.*; V.P. 1894, C. 1887-9, O. 1898.

1884 HOUCHIN, EDMUND KING . . *Durham House, Stepney, E.*

1889 HUMPHREYS, FRANCIS R. . . *27, Fellowes Road, South Hampstead, N.W.*; C. 1892-3 and 1895.

1884 JACKSON, GEORGE H. . . *Ashburton, Carew Road, Eastbourne*; C. 1890.

1897 JOHNSON, H. J., M.B. . . *37a, Finsbury Square, E.C.*

1897 KELSON, W. H., M.D. . . *96, Queen Street, Cheapside.*

1895 KER, HUGH RICHARD, F.R.C.S. . *Tintern, Balham Hill, S.W.*

1897 KERSHAW, W. H. . . . *6, Southgate Road, N.*

1893 KINGSFORD, EDWARD CLAUDE . *Carntyne, Brondesbury, N.W.*

1896 LANDON, E. E. B. . . . *Higham Court, Woodford Green, Essex.*

1892 LANG, WILLIAM . . . *22, Cavendish Square, W.*

1896 LEVY, A. G., M.B. . . . *29, Cumberland Terrace, N.W.*

1888 LONG, F. W. DEVEREUX . . *6, Spital Square, E.*

1896 LOWSLEY, L.D. . . . *101, London Wall, E.C.*

1892 LYON, THOS. GLOVER, M.A., M.D. *8, Finsbury Circus, E.C.*; Aud. 1895. C. 1896

1896 MCCLYMONT, JOHN, M.B., C.M. . *High Road, Leyton, Essex.*

1894 M'DONNELL, WM. CAMPBELL, M.D., *Park House, Park Lane, Stoke Newington, N.*

1891 MANSON, PATRICK, M.D., C.M., LL.D., *21, Queen Anne Street, W.*; O. 1894, C. 1895.

1891 MARSHALL, THOMAS, M.A., M.B. *95, Fortess Road, Kentish Town, N.W.*; C. 1894.

When Admitted.

1894 MITCHELL, ALEXANDER, M.D. . *41, Devonshire St., Portland Place, W.*
1896 NICHOLLS, S. R. . . . *185, Leytonstone Road, N.E.*
1890 OLIVER, FRANKLIN H. . . *2, Kingsland Road, N.E.*
1892 OLIVER, JOHN W., M.D., M.Ch. *Hackney Union Infirmary, Homerton, N.E.*; C. 1896-97.
1884 OPENSHAW, T. HORROCKS, M.S., M.B., *16, Wimpole Street, W.*; V.P., 1896-7, C. 1890-1, S. 1893-4-5.
1893 OSBURNE, CECIL A. P., F.R.C.S. *The Grove, Old Catton, Norwich.*
1896 PARKER, A. H. . . . *142, Grove Road, Victoria Park, E.*
1897 PARTRIDGE, WM. THOS. . . *97, Albany Road, Old Kent Road, S.E.*
1888 PERRY, E. COOPER, M.D. . . *Guy's Hospital, S.E.*; C. 1893.
1888 PITT, G. NEWTON, M.D. . . *15, Portland Place, W.*; C.* 1891-1893, O. 1895.
1882 POTTER, GEORGE W., M.D., C.M., *8, King Street, Cheapside, E.C., and Keldholm, Tunbridge Wells*, C. 1894-5.
1897 PRESTON, F. H., M.A. . . *119, East India Road, E.*
1892 RAWES, WILLIAM, M.B., F.R.C.S. *St. Luke's Hospital, E.C.*; C. 1896-7.
1888 REYNOLDS, W. PERCY . . *128, Stamford Hill, N.*; C. 1891-1893.
1896 ROBERTS, JOHN THOMAS . . *65, Park Road, Crouch End, N.*
1897 ROBERTS, THOMAS . . . *95, Tredegar Road, Bow, E.*
1894 ROGERS, G. A. . . . *404, Commercial Road, E.*
1897 RUSSELL, A. J. . . . *10, Lewisham Road, S.E.*
1895 RUSHBROOKE, THOS., M.A. . *89, Stamford Hill, N.*
1895 RUTTER, H. L., M.B., F.R.C.S. . *17, Victoria Sq., Stoke Newington, N.*
1897 RYAN, G. RUSSELL, M.D. . . *36, Great Eastern Street, E.*
1888 RYLE, REGINALD J., M.A., M.D. *Hadley Green, High Barnet, Herts.*; C. 1892.
1896 SARGENT, H. C. . . . *223, High Street, Shadwell, E.*
1884 SCARTH, ISAAC, M.B., B.S . *29, Amwell Street, E.C*; C. 1888.
1897 SCHORSTEIN, GUSTAVE, M.D. . *11, Portland Place, W.*
1892 SCOTT, PATRICK CUMIN, B.A., M.B., *38, Shooter's Hill Road, Blackheath, S.E.*
1892 SEQUEIRA, GEORGE W. . . *34, Jewry Street, Aldgate, E.C.*
1890 SEQUEIRA, HENRY J. . . *34, Jewry Street, E.C.*; C.* 1895-6.
1894 SEQUEIRA, JAS. H., M.D. . . *6, West Street, Finsbury Circus, E.C.*
1891 SHADWELL, ST. CLAIR B., M.D. . *Lynhurst, Orford Road, Walthamstow, Essex*; C.* 1895-6.
1888 SHAW, LAURISTON, E., M.D. . *10, St. Thomas's Street, S.E.*; C. 1897.
1896 SIMPSON, H. E. . . . *169, City Road, E.C.*
1887 SMITH, FREDERICK JOHN, B.A., M.D., *4, Christopher Street, Finsbury Square, E.C.*; V.P. 1897, C.* 1890-1, S. 1895-6.
1896 SNOWMAN, J. . . . . *75, Brick Lane, E.*
1896 STEEN, JAMES R., M.B. . . *413, East India Road, E.*
1896 STEVENS, THOS. G., M.D. . . *8, St. Thomas's Street, S.E.*
1892 STOCKER, CHARLES JOSEPH . *Weston House, Richmond Gardens, Forest Gate, E.*
1894 STONHAM, HENRY ARCHIBALD . *30, Albert Square, Ratcliff, E.*
1896 SUMMERS, T. C. . . . . *69, Bow Road, E.*
1880 SYMONDS, CHARTERS J., M.S., M.D., *26, Weymouth Street, Portland Place, W.*; P. 1894-5, V.P. 1891-2, O. 1891, C. 1887-8, S. 1883 to 1886.

When Admitted.		
1878	TALBOT, RUSSELL M. . .	*117, Bow Road, E.*; C. 1882.
1889	TARGETT, JAS. H., M.B., M.S. .	*6, St. Thomas's Street, S.E.*; C. 1896.
1880	THORP, HENRY J. . . .	*11, Southwark Bridge Road, S.E*; V.P. 1895, C. 1892-3.
1890	TUBBY, ALFRED H., M.B., M.S.	*25, Weymouth St., Portland Place, W.*; C. 1893-4, S. 1896-7.
1890	WALKER, CHAS. R., M.D. . .	*Glenfield, Silverdale Rd., Eastbourne.*
1887	WALLACE, FREDERICK . .	*Foulden Lodge, Upper Clapton, N.E.*; C. 1881, 1886.
1895	WALSHAM, HUGH, M.B. . .	*32, New Cavendish Street, W.*
1887	WARNER, PERCY . . .	*Rydal, Woodford Green, Essex*; C. 1890, 1893.
1895	WASHBURN, JOHN WYCHENFORD, M.D.,	*6, Cavendish Place, W.*
1896	WASON, R. L., F.R.C.S. . .	*64, Burgoyne Road, Harringay, N.*
1893	WILLIAMS, GEORGE ROWLAND .	*27, Queen Street, Cheapside, E.C.*
1897	WILLS, J. KENNEDY, . .	*Bethnal House Asylum, E.*
1895	WOOD, EDWARD . . .	*Glebe Lodge, Windmill Hill, Enfield.*
1887	WOODS, JOHN F., M.D. . .	*Hoxton House Asylum, N.*; C.* 1894-5.
1896	WORNUM, G. PORTER . .	*6, College Terrace, Belsize Park, N.W.*
1889	WRIGHT, HOLLAND H. . .	*2, Ospringe Road, St. John's College Park, N.W.*
1880	YARROW, GEO. E., M.D. . .	*26, Duncan Terrace, Islington, N.*; C. 1893.

The following gentlemen have been elected, but have not yet signed the Roll and been admitted :—

W. J. RADFORD	*Poplar Hospital.*
S. J. BOULTER	*11, Farquhar Road, S.E.*
F. W. MILES	*Parkside, Bowes Park, N.*

[*It is requested that any change of Title, Appointments or Residence may be communicated to one of the Secretaries before the Annual General Meeting, in order that the list may be made as correct as possible.*]

CORRESPONDING FELLOWS.

BARLOW, ROBERT	*Orlebar, St. Peter's, Isle of Thanet;* C. 1886.
BARNARD, JOHN H., M.D. . .	*362, Rue St. Honoré, Paris.*
CANFIELD, RALPH M. . .	*Boston, U.S.A.*
ENGLISH, EDGAR	*Mexborough, Rotherham, Yorks.*
HIRSCH, CHAS. T. W. . .	*Fiji.*
PIERCE, BEDFORD, M.D. . .	*The Retreat, York.*
ROBERTS, BRANSBY, M.D. . .	*Badlesmere House, Eastbourne.*
TREVES, WILLIAM KNIGHT, F.R.C.S.	*31, Dalby Square, Margate.*

N.B.—Written Communications on Medical Subjects and Donations of Books will be thankfully received.

THE SEVENTY-EIGHTH ANNUAL REPORT

OF THE

COUNCIL OF THE HUNTERIAN SOCIETY.

The Society has during the past year continued to show signs of great vitality and energy. For some three years now a record has been kept of attendances at the meetings, on the average this has, by a very small decimal, been inferior to last year, but it is still by no means discouraging.

The year's work commenced with the ANNUAL ORATION by Dr. G. Newton Pitt, on the subject of "John Hunter as a Physician ; and his relation to the Medical Societies of the last century." Dr. Pitt showed us another side to John Hunter's versatile genius, viz., the medical one ; and his lecture contained many illustrative clinical cases in the diagnosis of which Hunter showed his usual acumen : the latter half of the Oration dealing with Hunter's relations to the Medical Societies was considered to have a wider interest, and was published in full in Vol. I. of the Lancet for 1896.

In February, 1896, Knowsley Thornton, Esq., delivered the first HUNTERIAN SOCIETY'S LECTURE, in which he dealt with "The Lines of Advance in Abdominal Surgery." As Mr. Thornton himself has been and is one of the pioneers in this branch of surgery, his lecture was particularly and peculiarly interesting and instructive ; it too has had a wider publicity given to it than our Transactions alone, and will be found in full in the British Medical Journal, Vol. I., 1896. At the last meeting before the summer recess, Mr. Targett gave a most valuable lantern demonstration on "Joint changes which are associated with Nervous Diseases." The meeting was held in the reference library, and was largely attended by a very appreciative audience.

At the commencement of October the second Hunterian Society's Lecture was delivered by Dr. Stephen Mackenzie, a former President, who chose for his subject " Purpura : its

nature, varieties, and treatment." He dealt in his usually masterly manner with a large mass of statistics and details, which thus handled gave a complete account of the disease.

Besides these evenings, which were of exceptional interest, there have been many papers, cases, and demonstrations which have attracted great attention from the Fellows of the Society: Dr. P. Warner's and Mr. Symonds's paper on Typhlitis; Dr. McClymont's on the the infectious nature of Rheumatism; Dr. Davies's on the treatment of Chronic Bronchitis, may be mentioned. The cases of Cervical Neuralgia originally shown to the Society by Sir Hugh Beevor and subsequenty by Dr. Woods, excited much comment on the very successful treatment by suggestion which the latter gentleman had carried out. Altogether the Council is of opinion that the year's work done by the Society is of a very satisfactory nature.

As regards our numerical strength the following facts are very encouraging. Since January, 1896, twenty-six new Fellows have signed the Roll of the Society and we have now 176 names on the active list, in addition to our Honorary and Corresponding Fellows. Four Fellows only have resigned (viz., Messrs. Barrett, Beswick, George, and Morley), and one name (that of Mr. Raw) has been removed from the list by order of the Council.

Lord Lister who is an Honorary Member of our Society has been raised to the Peerage, a well deserved reward, which honours not Lord Lister only, nor our Society, but the whole medical profession.

Death has removed from us three Fellows, viz., Messrs. Gowlland, Blandford, and Welch. Mr. Gowlland joined the Society in 1862, and advanced age had long removed him from the ranks of the active members of the Society, while in contrast to this, Dr. Blandford had only joined us in January, 1896, so that he had scarcely time to display any great activity in the discussions at our meetings.

The financial condition of the Society is presented on another page as a report from the Treasurer and Auditors and Librarian, and is very satisfactory.

REPORT OF THE LIBRARY COMMITTEE, 22nd JANUARY, 1897.

We have inspected the books forming the Library of the Hunterian Society, and find them to be in a generally satisfactory condition. The bookcases and cupboards are all in order. Eighteen volumes have been borrowed during the year, four from the Permanent Library, and fourteen from Lewis's Library. Seeing the use that has been made of Lewis's Library since the Council decided to recommend the subscription, the Committee recommend the increase of that subscription from two to three guineas. We think that the details of the method of supply of books by Lewis's could be usefully revised. We also suggest to the Council that a supplementary catalogue, containing recent additions to the Permanent Library, should be issued to the Fellows.

On behalf of the Committee,

R. Hingston Fox,
H. J. Sequeira,
John W. Oliver,
Arthr T. Davies, *Hon. Librarian.*

BOOKS ADDED TO THE LIBRARY OF THE HUNTERIAN SOCIETY.

February, 1896, to February, 1897.

Presented :—

Index Catalogue of the Library of the Surgeon-General's Office, U.S.A. Army, Vol. i., 2nd Series.
St. Bartholomew's Hospital Reports, 1895.
Guy's Hospital Reports, 1895.
The Geological and Natural History Society of Minnesota, 1894 and 1895.
Flushing and Morbid Blushing—Harry Campbell.
The Causation of Disease—Harry Campbell.
Difference in the Nervous Organisation of Man and Woman—Harry Campbell.
Twenty-fifth Annual Report of the Local Government Board, 1895-6.
Archives of Surgery, Vol. vii., Nos. 25 to 28.
Prælectiones Anatomia Universalis—William Harvey.
Clinical Society's Transactions, Vol. xxix.
Pathological Society's Transactions, Vol. xlvi.
The Clinical Journal.
The Journal of Dental Science.

PURCHASED BY THE SOCIETY:—

Medical Digest—Neale.

Pictorial Atlas of Skin Diseases and Syphilitic Affections—edited by J. J. Pringle.

New Sydenham Society's Transactions:—(1) Lectures on Pharmacology, Vol. II.; (2) Leprosy Prize Essay; (3) Treatment of Cholelithiasis.

REGULATIONS FOR TRANSMISSION OF BOOKS TO FELLOWS FROM THE LIBRARY.

1.—A Fellow wishing a Library Book sent to him, may order the book by letter to the Assistant Librarian, enclosing six stamps in pre-payment of carriage and packing.

2.—The Library Attendant will pack and send books to Fellows, enclosing the usual receipt form in each parcel with the books, and shall receive twopence for each packet so sent.

3.—To prevent loss, in case of a Fellow forgetting to send back the receipt, the letter requesting the book to be sent shall be kept by the Assistant Librarian, and the Library Attendant shall keep a list of the books packed by him, and of Fellows to whom they have been sent.

ANNUAL DINNER, 1897.

The ANNUAL DINNER of the Society took place on Friday, February 12th, 1897, at the First Avenue Hotel, at 7 p.m.; the President in the chair.

Fifty-three Fellows and guests were present. After dinner the usual loyal toasts were given by the President, and then the following were duly honoured:

"The Hunterian Society," proposed by the President and responded to by Dr. Gervis.

"The Visitors," proposed by Gordon Brown, Esq., and responded to by Prof. Stewart.

"The Sister Societies," proposed by Charters Symonds, Esq., and responded to by Mr. Reginald Harrison.

"The Hunterian Society's Lecturers," proposed by Dr. Horrocks and responded to by Dr. Hingston Fox.

"The President," proposed by Dr. Fox.

"The retiring Hon. Secretary," proposed by the President.

The President in replying mentioned that one of the Fellows present was Dr. Crosse, late Medical Officer to the Niger Company, who was well acquainted with West Africa.

Dr. W. H. Crosse, having been called upon, made an interesting and humorous speech, in which he testified to the good work done by the Niger Company.

The intervals between the speeches were filled by music.

BALANCE SHEET FOR 1896.

HUNTERIAN SOCIETY IN ACCOUNT WITH THE HON. TREASURER.

RECEIPTS.

	£	s.	d.
By Balance from 1895 a/c	67	7	0
,, Subscriptions :—			
85 Current for 1896	89	5	0
17 Arrears	17	17	0
10 In Advance	10	10	0
25 Entrances	26	5	0
4 Composition Fees	25	0	0
	164	17	0
,, Dividends on £332 8s. 6d Goschens	8	16	8
,, Balance of Conversazione Fund	17	17	6
	£258	18	2

PAYMENTS.

	£	s.	d.
To London Institution	30	0	0
,, Messrs. Headley Bros. for printing Annual Report, etc.	52	8	2
,, Free School Press for circulars	5	2	0
,, Subscription to Messrs Lewis's Library	2	2	0
,, Subscription to New Sydenham Society	1	1	0
,, Messrs Kitcat for binding Lancet	1	4	0
,, The Lancet (3 half-years)	2	5	6
,, Hon. Secretary's disbursements	7	6	9
,, Reporting Discussions and Lantern	3	4	1
,, Refreshments at meetings, etc.	4	13	5½
,, Insurance	1	0	0
,, Collector for 1895	3	11	6
,, Collector for 1896	4	4	0
,, Hon. Treasurer for postage		11	0
,, Cheque Book		2	1
,, Guests at Annual Dinner	3	5	6
,, Purchase of £16 7s. 11d. Goschens	17	17	6
	£139	18	6½
To Balance	118	19	7½
	£258	18	2

We, the undersigned, having examined the foregoing accounts together with the vouchers, find the balance due from the Treasurer to be £118 19s. 7½d.

And that the funded property of the Society is £332 8s. 6d. Goschens in the names of the Trustees.

A. Gordon Brown,
Hope Grant.

THE ANNUAL ORATION, 1897.

WILLIAM HUNTER

(1718-1783),

ANATOMIST, PHYSICIAN, AND OBSTETRICIAN,

With notices of his friends Cullen, Smellie, Fothergill, and Baillie.

By R. HINGSTON FOX, M.D., M.R.C.P.

Mr President, and Fellows,

I have thought that I could most fitly discharge the duty which your kindness has laid upon me this evening, by bringing before you the life of one worthy of your honour, William Hunter, elder brother of John Hunter, after whom this Society is named.

WILLIAM HUNTER, LECTURER ON ANATOMY.

In one of the issues of a London newspaper in January, 1746, there was to be read an advertisement in the following terms:—"On Monday the 1st of February, at 5 in the afternoon, will begin A Course of Anatomical Lectures. To which will be added, the Operations of Surgery, with the application of Bandages. By William Hunter, Surgeon. Gentlemen may have an Opportunity of learning the Art of Dissecting, during the whole Winter Season, in the same Manner as in Paris."

This announcement followed the custom of that day, by combining within the scope of one course of lectures, Anatomy, the operations of Surgery, and the application of bandages. The lectures were commonly given at the house

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*** The portrait of William Hunter is taken from an unpublished medallion in the Hunterian Museum, Glasgow, by kind permission of Professor J. Young. That of Cullen is from an engraving by Ridley, 1803. That of Fothergill is reduced from the fine plate by Bartolozzi, prefixed to the third volume of his works, by Lettsom, 1784. Dr. Glaister kindly permitted a similar reduction from the photogravure of Smellie (taken from an oil painting) which adorns his Memoirs.

Life and Times of Dr. William Hunter.

1710	Birth of Cullen.	
11		
12	Birth of Fothergill.	
13		† Bidloo (Leyden).
14		† Radcliffe. George I.
15		† Louis XIV.
16		
17		
18	*Birth of William Hunter at Long Calderwood, Lanarkshire.*	
19		
1720		Westminster Hospital founded.
21		Inoculation for Smallpox.
22		
23		† Valsalva (Bologna).
24		Guy's Hospital founded.
25		
26		
27		† Sir Isaac Newton. George II.
28	Birth of John Hunter.	† Freind.
29		† Sir R. Blackmore.
1730		
31	*Studies at University of Glasgow.*	† Ruysch (Amsterdam).
32		
33		St. George's Hospital founded.
34		† Stahl (Halle).
35		† Arbuthnot.
36		Linnæus' "Systema Naturæ."
37	*Pupil of Cullen, at Hamilton, till 1740.*	
38		† Boerhaave (Leyden).
39	Smellie settles in London.	
1740	*Studies at Edinburgh.*	London Hospital founded.
41	*Comes to London.* Death of his Father.	
42	† James Douglas.	† Fr. Hoffmann (Halle).
43	*Paper on "Articulating Cartilages," before Roy. Soc.*	
44	Cullen lectures at Glasgow.	
45		Corporation of Surgeons founded. Middlesex Hosp. founded.
46	*Begins to Lecture.*	Franklin's Electrical discoveries.
47	*Member of Corporation of Surgeons.*	Haller's Physiology.
48	*Visits Holland.* John Hunter comes to London.	
49	*Surgeon-accoucheur to British Lying In Hospital.*	
1750	*M.D. Glasgow. Established in Jermyn Street.*	† Petit (Paris).
51		
52		† Cheselden. † Sir Hans Sloane.
53		
54	Smellie's "Anatomical Tables."	† Richard Mead.
55	The Hunters discover Placental Circulation.	
56	*Licentiate of the Royal College of Physicians.*	Black on Latent Heat.
57		Battle of Plassey.
58		
59	Smellie retires to Scotland ; (died 1763).	
1760	John Hunter abroad with the Army.	Pott on Head Injuries. George III.
61	*Engages Hewson as Assistant.* Birth of Baillie.	Morgagni "De Sedibus." Gaubius's "Pathology."
62	*Consulted by the Queen.*	
63	John Hunter settles in London.	
64	*Physician Extraordinary to the Queen.*	
65	*Attempt to start National School of Anatomy.*	
66		
67	*F.R.S.* John Hunter, F.R.S.	Sir Geo. Baker on the Devonshire Colic.
68	*Prof. of Anatomy to Royal Academy.*	† Huxham (Plymouth).
69		Year of momentous Births (Bonaparte, Wellington, Ney, [Mehemet Ali, Brunel, Humboldt, Sydney Smith, etc.)
1770	*Moves to Great Windmill Street. Cruikshank, Assistant.*	† Albinus (Leyden). † Akenside.
71	John Hunter marries.	† Morgagni (Padua).
72		Watts invents Steam Engine.
73		Medical Society of London founded.
74		† Hewson. Priestley discovers Oxygen.
75	*Publishes "Anatomy of Gravid Uterus."*	
76		
77	Cullen's "First Lines."	† Haller (Berne).
78		Sir Jos. Banks, President Roy. Soc. (until 1820).
79		Cavendish discovers composition of Air.
1780	*Dispute with John Hunter.* † Fothergill.	
81	Matthew Baillie comes to London.	Brown's "Elementa Medicinæ." Baudelocque on Accouchements.
82	*Foreign Associate of French Academy.*	Herschel discovers Uranus.
83	*Death.* John Hunter moves to Leicester Square.	American Independence. William Pitt, Premier.
84		
85		
86		
87		Linnæan Society founded.
88		† Percival Pott. Steam Navigation.
89		† Cowper. Lavoisier's "Traité de Chimie." French Revolution.
1790	† Cullen.	† John Howard. Erasmus Darwin, "Loves of the Plants."
91	† Wm. Pitcairn.	Goethe on Development of Skull.
92		† Louis. York Retreat for the Insane.
93	Death of John Hunter.	
94	John Hunter's "Treatise on Inflammation."	Dalton on Colour Vision.
95	Baillie's "Morbid Anatomy." (Died 1823.)	
96		Vaccination discovered (Jenner).
97		Count Rumford on Heat.
98		Battle of the Nile.
99	Corp. of Surg. acquire John Hunter's Museum.	
1800	(Wm. Hunter's Museum moved to Glasgow, 1807).	Royal College of Surgeons established by charter.

(For Dr. Hingston Fox's Oration before the Hunterian Society, Feb. 10, 1897.) [† *Signifies "Death of."*]

William Hunter.

of the lecturer, or in some convenient room elsewhere: but Nourse in 1737 set a novel precedent by holding his classes at St. Bartholomew's Hospital itself, "designing" he says in his advertisement, "to have no more lectures at my own house": his syllabus in 1748 included *totam rem anatomicam* in 23 lectures,—so limited was the knowledge of anatomy in those days. Later, in 1772, we find Dr. Saunders, and in 1776, Mr. Else, lecturing in the theatres of Guy's and St. Thomas's Hospitals respectively, but it was long before the custom of lecturing on the Hospital premises became usual. Thus Dr. James Maddocks, Physician to the London Hospital, lectured on the theory and practice of medicine in 1772, "in a large room in the Hotel, No. 5, Capel Court, opposite the Bank, in Bartholomew Lane." But the advertisement of lectures by Mr., afterwards Sir William, Blizard, and Mr. Thomas Blizard, in 1797, mentions their delivery in the Theatre of the London Hospital.

It was the retirement of Samuel Sharpe, Surgeon to Guy's Hospital, from his engagement of delivering an annual course of lectures before a Society of Naval Practitioners in Covent Garden, which made way for young William Hunter to take his place. Thus commenced his lecturing career in London, a career which lasted nearly forty years, and terminated only with his death.

William Hunter was at this time twenty-eight years of age, rather short of stature and slight in build, with delicate, almost feminine features, a refined, expressive face, and a certain notable brightness of the eyes. His address was pleasing, his words clear and precise, and he was fertile in illustration and humour.[1] He wore the wig, at that period in great use, even by boys at school who belonged to the well-to-do classes.

ORIGIN AND EARLY HISTORY.

William Hunter had been five years in London. He was the seventh child of a large family, John Hunter being the tenth and youngest, born in the old house, yet standing, of Long Calderwood in Lanarkshire. Of this family, four died in childhood at 1, 3, 14, and 17 years, and three at 25, 30, and 36 years of age—two of these from phthisis, and probably

1 "His dialect had all the polish of the Southern metropolis, with enough of the Northern recitative to preserve the close of his sentences from too abrupt a cadence." Adams, Memoirs of J. Hunter, p. 118.

others from tubercular affections,[1] one being James, a young anatomist of much promise: whilst three only lived beyond middle life—William, who died, gouty, at 65; John, died with aneurysm of the aorta, also at 65; and Dorothy, the mother of Matthew Baillie.

If as a family however, they enjoyed poor vitality, such members as lived were endowed with energy, industry, and talent far beyond the common lot of man. It is not without interest to follow the history of the stock a little farther. Of the ten sons and daughters, only two, John and Dorothy, left issue. Of John's children, two died young, two lived, but died without issue. Of the talented children of Dorothy Baillie, one, Matthew Baillie, never robust, died worn out at 62, leaving a son and daughter; the other two lived unmarried to 100 years or near it.

Extraordinary powers of mind are not uncommonly associated with a like strength of body, leading to prolonged old age, but the possession of genius is not favourable to the perpetuation of the species.[2]

The shadow of death, which had so often darkened the home at Long Calderwood, seems to have endeared the survivors to one another. Affectionate letters between the brothers and sister have been preserved: although in the youngest brother, John, the family bond was not so strong.

The father of the Hunters was a man of high character, and made many sacrifices to advance his children: his anxious disposition kept him, we are told, often awake at night, pondering his cares. He writes shortly before his death to his son William, who had had an offer of work in London, that nothing had proved a greater comfort to them all than the hopes of seeing him:—"I surely must soon expect to (leave this) side of time, considering my age and present Indisposition, being (for some) days past confined to my bed with sickness, and a severe fitt of (the) gravel, and would be glad to have you near me for the little while

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1 Mr. W. Hunter-Baillie (who died 1894, aged 96 years), son of Dr. Matthew Baillie, used to say that those who died young died of consumption.

2 Descendants of Archibald, only paternal uncle of the Hunters, still exist; several have been in the medical profession. His grandson, the late Dr. William Hunter, of Largs, was an army surgeon, present at Waterloo. Dr. William Hunter, of Rothesay, who died in 1893, was grand-nephew and heir to the latter, and has left children to inherit certain Hunterian heirlooms: another grand-nephew is Dr. Charles B. Hunter, of Secunderabad, India.

(I may) be in this world, tho' at ye same time, I should be sorry to hinder you (from) making your way in the world the best way you can. I wish you (to) consider well what you do."[1]

William Hunter went, at the age of thirteen, to the University of Glasgow. His father intended him for the Church, but his enquiring mind did not readily accommodate itself to the unyielding tenets of the Presbytery. He became acquainted with William Cullen, then in medical practice in the town of Hamilton, a man eight years his senior in age ; and spent three years residing as a pupil in his house, until he was 22 years old. They were, he tells us, the happiest of his life.

Hunter's choice of the profession of medicine was one result of this residence with Cullen. Another result was a lifelong friendship between the two Scotsmen. In an age when near relatives addressed each other as "Dear Sir," Cullen and Hunter are "My dear Willie," or "My dear old Friend," and the letters which have been preserved, for they seldom met in after life, form a valuable source of our knowledge of Hunter's true character.[2]

After a winter spent in Edinburgh attending the classes of Dr. Alexander Monro and others, William Hunter came, in the year 1741, to London. The journey was made by sea, and in the voyage from Leith they encountered a severe storm, and were in much peril of shipwreck.

He seems to have had but few introductions to the metropolis. The first was to Smellie, and at his house, or rather apothecary's shop in Pall Mall, he stayed for some time. William Smellie was like himself, an able, active, young Scotchman, ambitious of a wider scope for his abilities. Smellie and Hunter both became leaders in Obstetric Medicine in London. We shall have to compare their careers later on.

Another of Hunter's introductions was to Dr. James Douglas, the anatomist, and this proved of great value and importance to him. Douglas was an original worker of no mean repute ; he is known familiarly to us all as the discoverer of Douglas's pouch, and he made likewise new and intimate dissections

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1 Hunter-Baillie MSS., Roy. Coll. Surg., vol. I., p. 58.

2 See Thomson's Life of Cullen, Vol. I.

of the peritoneum and its cavities. He was also an accoucheur, and is referred to in the lines :—

> "There all the learn'd shall at the labour stand,
> And Douglas lend his soft obstetric hand."

Douglas was now approaching old age, and needing some help in his anatomical work. He discerned the abilities of young Hunter, and proposed to him to enter his household, acting as tutor to his son, and assisting himself.

Hunter, who was seeking for the means of a livelihood, accepted the offer, and lived with Dr. Douglas until he died next year, and then continued to reside with the widow and family. His relations with them were kind and intimate : Douglas expired, wrote Hunter to his mother, with his hand locked in his own.[1] In the meantime, Hunter attended the classes of Nicholls, another famous anatomist, and was surgeon's pupil at St. George's Hospital, then recently founded. It is not unlikely that as Cullen had inclined him to medicine, and Smellie had interested him in obstetrics, so it was Douglas who fostered in his mind the liking for anatomy.

It is as anatomist, physician, and obstetrician, that I desire to bring Hunter before you this evening.

MEDICAL LEADERS IN 1746.

And here let us pause to consider who were the leaders of medical science 150 years ago.

Sydenham, the English Hippocrates, had been dead for over half a century ; Radcliffe for thirty years, and Dr. Richard Mead, his successor, was now the leading medical luminary in London. A coach and six carried Mead from his country seat near Windsor to a town house, situated where the National Hospital for Epilepsy now stands, and in its galleries the Mæcenas of medicine had gathered a library and museum of art which were famous throughout Europe. Freind was dead, as was the accomplished Arbuthnot, but Sir Hans Sloane was yet living at a great age, physician to the King, and the possessor of a large collection of the curiosities of nature and art, destined to form the nucleus of the British Museum. Huxham, who

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1 Hunter-Baillie MSS., II., 3.

had been a pupil of Boerhaave at Leyden, was in active work at Plymouth ; his tincture of bark yet holds its place in our pharmacopœia.

The most distinguished anatomist and surgeon was William Cheselden, now approachiug old age. Percival Pott was in the early years of his work at St. Bartholomew's Hospital.

Looking abroad, eight years only had passed since the illustrious Boerhaave died at Leyden—*animum vix quisquam diviniorem, omnium amantem*—yet in the person of faithful pupils, such as Haller, then at Göttingen, De Haen, and Van Swieten, the great eclectic physician lived on, and the impetus he had given to the rational culture of the art of healing and its emancipation from the trammels of tradition bore fruit in many lands. The leading physicians in Edinburgh were disciples of Boerhaave, as were our own Mead and Huxham and many more. Friedrich Hoffmann and Stahl, in some sense rivals of Boerhaave, and each founders of a system or doctrine of medicine, were also dead.

The great anatomists of the two previous centuries, such as Vesalius, Fallopius, our own Glisson, Valsalva, Malpighi, and Bidloo, had left some successors. Ruysch, of Amsterdam, famous for his beautiful preparations, was not long dead ; Petit, of Paris, was yet living, though old, whilst Albinus, another pupil of Boerhaave, who occupied the chair of anatomy at Leyden for the long term of fifty years, was at the height of his reputation and activity.

In the department of pathology the science of morbid anatomy had been created by Soemmerring and Morgagni[1]. The latter was already old, but he lived many years yet, untiring in his dissections, and lecturing to his class at Padua to extreme old age. He published his great work, "De Sedibus et Causis Morborum," in 1761.

The science of botany was taking its first form and order under the genius of Linnæus, at this time at the height of his fame, Professor of Medicine at Upsal, and Superintendent of the Botanic Garden.

OUTLINE OF WILLIAM HUNTER'S LIFE.

We now return to William Hunter, entered upon his career as a lecturer on anatomy. He was so generous in

1 *Der Begrunder der Neuen Pathologischen Anatomie.*—Haeser.

helping his friends from the fees he had received, that he found himself on the approach of the second session without the means of advertising the course.

In the meantime he practised surgery, having in 1747 become a member of the Corporation of Surgeons. In the next year he travelled on the Continent with young Douglas, going through Holland to Paris, and visiting some of the medical schools. In particular he went to Leyden, to Albinus, just alluded to, and saw some of the injected preparations for which that anatomist was famous, and was led to use this method of investigation in his own future work with signal success.

In 1748 his youngest brother John, ten years his junior, came up to London, fired, it would seem, by the same desire of a larger field for his energies. He wrote to offer his services to William as an assistant in his dissecting room. William replied with a kind invitation to visit London.

John Hunter became at once his brother's pupil and assistant, and was inducted by him into the anatomical studies in which he was to spend most of his life. He soon showed great skill in dissecting and injecting specimens, and assisted his brother in many of his researches in anatomy and physiology, making discoveries more or less in conjunction with him. These, as we shall see, were afterwards a fruitful source of dispute between them.

For several years after John came to London, his elder brother sought to direct and help him in his studies, placing him under Cheselden and under Pott. He even tried to give him what he had himself enjoyed, a University training, but John's stay at Oxford was very brief and to little purpose, and he referred very ungraciously in after life to the efforts that had been made on his behalf. Indeed, it must be acknowledged that the younger brother gave, for a good many years, little comfort or satisfaction to his friends. His manners were rough and coarse, and his associates low. Indications of this occur in the letters which have been preserved.

The dispositions and training of the two brothers were so different that it is hardly to be wondered at that they diverged as years went on. William, with his culture and polite instincts, had a trait of strictness and severity in his character, although he was kind at heart. Yet he refers often to his brother John in his lectures and in his medical

commentaries in appreciative terms ; and it was principally through William's powerful interest that John was elected to his most important appointment in the year 1768, that of surgeon to St. George's Hospital.[1]

John once sent him a patient with the following laconic note :—" Dear brother,—The bearer is very desirous of having your opinion. I do not know his case. He has no money, and you don't want any, so that you are well met. Ever yours, John Hunter."

John left his brother's laboratory in or before 1761, going abroad on account of his health as a Surgeon in the Army, and was succeeded by Hewson, a very able young anatomist with whom after some years William disagreed, and Cruikshank was engaged in his place in 1770. Hewson made important researches into the lymphatic system, discovering the existence of these vessels in birds and fishes, and demonstrating the human lymphatics with a fulness hitherto unattained. He died at the age of 34 ; his works have been published by the Sydenham Society. A curious letter is extant from Benjamin Franklin, who, during his stay in England, lodged at one time with William Hunter and Hewson, and "as a common friend had been obliged to listen to their mutual complaints." He writes to William Hunter in 1772 to give evidence as to the terms of agreement between them.[2]

In 1750 William Hunter received his degree of Doctor of Medicine from Glasgow University, gave up surgical practice, and left the hospitable roof of Mrs. Douglas to take a house in Jermyn Street, where he practised as a physician.

By this time he had made various communications to the Royal Society ; the first was as early as 1743, when he was aged but 25, on " The Structure and Diseases of Articulating Cartilages."

At that time, and indeed throughout the 18th century, papers on medical subjects were laid before the Royal Society in large numbers. He was elected a Fellow in 1767, in the same year as his brother. It may be added here that in 1768, on the foundation of the Royal Academy by Joshua

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1 Adams (*Op. cit.*, p. 115) states that John Hunter's appointments to the army, and as Surgeon to the King, were in like manner owed to William's influence.

2 Hunter-Baillie MSS., I., 126.

Reynolds, Gainsborough, and others, Dr. Hunter was appointed its first Professor of Anatomy.[1] A painting in the Royal College of Physicians, of which he became a Licentiate in 1756, represents Hunter lecturing to the members of the Academy.[2]

In his practice Hunter had come to turn his attention especially to midwifery, and he had been appointed man-midwife to the Middlesex Hospital in 1748, and Surgeon Accoucheur to the British Lying-In Hospital next year. In this branch of medicine his reputation constantly grew, until in the year 1762, when he was forty-four years of age, he was called in to see the young Queen of George the Third. The story is told, but I have found no written authority for it, that the King asked him when he came out of the chamber, what ailed her majesty, and that he replied, "The Queen is *with bairn*." In any case his attendance gave much satisfaction, he was two years later named as Physician Extraordinary to the Queen, and from this date his practice amongst the upper classes rapidly increased. Hunter's polished manners and refinement, coupled with much shrewdness, and a careful attention to his patients, made him a *persona grata* with persons of rank, whether by title or talent. The letters existing prove that he was on terms of easy acquaintanceship with many of the nobility, such as the Earls of Chatham and Rockingham, Lords North, Bute, and Newborough. Horace Walpole writes to him in 1773 to promise him Lord Orford's "Orignal"—an American Moose deer.[3]

The historian Gibbon attended some of his lectures, and David Hume, little as Hunter must have sympathised with his philosophical views, was an intimate friend. A letter has been preserved, written in 1775 by the Bishop of Down and Connor, begging Dr. Hunter to use his influence with Mr. Hume, to prevent his coming to Ireland, where, says the Bishop, his character as a philosopher was an object of

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1 The Diploma dated December, 1768, bearing George III.'s signature and the seal of the Academy, is displayed on the wall of the Hunterian Museum, Glasgow.

2 Hunter is demonstrating the muscles of the thorax on a living subject to an audience of about 25 persons.

3 Hunter-Baillie MSS., I. 128. I have to thank my friend Mr. T. A. Cotton, F.L.S., for identifying this animal: it is probably the specimen preserved in the Museum at Glasgow.

universal disgust.[1] Eleven years later Cullen writes to Hunter to give an account of Hume's last days, and gives a striking picture of the calmness of the philosopher on the approach of death.[2]

Hunter's character is placed in a favourable and interesting light by some letters which passed between him and the Earl of Suffolk, whose lady he had attended at her death in childbed in 1767. Lord Suffolk had addressed to Dr. Hunter a letter full of the most affectionate gratitude for his attention and help: "My busyness is to beg of you, if *Reward* is an irksome word, to let me substitute *Regard* in its room." Dr. Hunter, after warmly thanking Lord Suffolk for his letter, continues: "I am now by your Lordship's kind sympathy, as happy as I can be, after taking such a share in so great a calamity. I feel an inclination to say a thousand things which I must suppress. I wish to talk upon a subject which you must forget. We will take it up in Heaven. At this moment I fancy that I have a Friend there who listens to my thoughts, and bids me say to you in a little time we shall all be happy again; who bids me tell you, to take care, for her sake, of yourself and of your child.

"Allow me to love your child all the days of my life: she will be exactly what you describe and what you wish. Allow me sometimes to see her, that I may indulge a pleasing melancholy and fancy that I am doing something very agreeable to Heaven. It may be preparatory to some exalted enjoyment there. Allow me likewise to offer your Lordship the best advice I can. As soon as possible, do a force to nature and go into the bussy world again. Nothing but that, I think, can restore your peace of mind and make you what I am sure you wish to be, a Blessing to Mankind. May you yourself be blest, both for your own sake, and for loving so tenderly one so worthy of all your affection."[3]

Nor was Hunter's acquaintance confined to his own country. He maintained correspondence with friends abroad,

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1 Ib. 89, 92. 2 Ib. 139, cf. 141, 142.

3 Ib. pp. 102-4. Henry, 12th Earl of Suffolk, K.G., was Secretary of State for the Northern Department. He was devotedly attached to his lady, and after her death, cared only to live for the child. She died at the age of eight years, and then Lord Suffolk married again, though he could never shew again the deep devotion he had given. He died aged only 39. The story of his loves and sorrows has come down through a favourite niece, who lived to nearly 100 years, and told it to the present Countess of Suffolk, to whose courtesy I am indebted for this information.

sometimes in the Latin language, in which he was well versed. At this time too, he was collecting for his Museum. The brothers Hunter were rivals in this also, that each formed a large Museum for teaching purposes. Anatomical preparations were the first object, but John, as is well known, added other departments of natural history, until he had drawn together the magnificent collection, which, enriched by later workers, adorns the Royal College of Surgeons in this city.

William Hunter took a yet wider range. Anatomy, healthy and morbid, was his first care. "The completeness," writes Professor John Young, M.D., the present Curator, "with which every organ is represented, in its normal and morbid conditions, indicates the systematic purpose with which he started ; and the exquisite beauty of the injections, vermilion and mercury, attest his great manipulative skill." Then Biology, in its whole scope as then known, was represented : stuffed animals, such as the elephant : and Hunter bought entire collections of shells, insects and minerals, as they came into the market. He included the spoils of Captain Cook's voyages, the weapons and implements of savage nations ; antiquities of all ages and climes ; books, not alone medical and scientific, but a fine series of the classics, and of early printed books and manuscripts, some of them illuminated.[1] His taste in art led him to obtain engravings, and a choice collection of specimens of the work of the best painters of all schools. Lastly his cabinet of coins, the object of unceasing care and lavish expenditure, contains 35,000 pieces, and is one of the finest known. The entire Hunterian Museum was taken to Glasgow in 1807 in accordance with Hunter's will : it has during recent years been well displayed in new quarters in the large University buildings in that city : but it is to be feared that its treasures are less known and used than they deserve to be. A proposal was mooted, a few years since, to sell the coins ; Mr. William Hunter Baillie, then living at a very advanced age, viewed this proposal with indignation, and wrote that, as Hunter's heir, he should claim the money. The project was abandoned.

He sought, but sought in vain, to construct on the basis of this Museum and his lecture classes a National School of

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1 See for an account of the bibliographic treasures " An Address on the Hunterian Library, by John Young, M.D , Glasgow, 1897."

Anatomy. He was ready to erect the building and to endow it with the sum of £7000. But his application in 1765 to the Government of the day to grant a site was unheeded, and the golden opportunity which might have done much for British Medicine was suffered to pass by. It was a bitter disappointment to Hunter, and although Lord Shelburne sought as an individual to undo the ill act of the Cabinet, and offered to head a subscription list with a promise of a thousand guineas, Hunter's pride would not stoop to accept it. He turned to rely upon his own unaided efforts. A plot of ground was purchased in Great Windmill Street, near the present Piccadilly Circus, and here in 1770 he built a spacious house, containing a large room for his museum, a lecture theatre, and dissecting rooms, besides rooms for his own residence. Here he lived and taught for the remaining thirteen years of his life. The house was afterwards occupied by his nephew Dr. Matthew Baillie, and it was here that Joanna Baillie began to write her dramas : it still stands, a plain red brick structure, somewhat altered, the portico gone, and the building now incorporated in the Lyric Theatre.[1]

Hunter was a keen and jealous controversialist, laid exaggerated stress upon his own discoveries, and was too sensitive of his fame as an original worker. He was conscious of this weakness, an inordinate love of controversy : and condoned it on the plea that the passive submission of dead bodies rendered anatomists impatient of contradiction.

Vehement and bitter was his dispute with the Monroes, father and son. In the discovery of the tubuli testis, however, both he and they had been anticipated by Haller, who had announced his discovery before 1750.

Old Baron Albrecht von Haller, who had been Professor of Medicine and Anatomy at Göttingen, but was now at

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1 The house of John Hunter on the East side of Leicester Square, containing his lecture theatre, dissecting rooms, etc., is at this very time about to be absorbed by the Alhambra Music-hall which adjoins it. An original drawing by Rowlandson, now in the Conservator's room at the Roy. Coll. of Surgeons, depicts "the Dissecting Room" of Dr. W. Hunter at Great Windmill Street. The large room is crowded : several bodies are exposed. Hunter's figure is raised above the rest : Hewson dissects an eye, Howison the intestines, whilst Cruikshank above him looks on, and Smollett's big form is seen, eyeglass in hand. Pitcairn, Baillie, Home, Sheldon, Camper and others have been supposed to be represented, but Baillie was not in London until six years after Hewson's death. Mr. J. B. Bailey, who has reproduced the picture in his "Diary of a Resurrectionist," identifies a figure upon W. Hunter's right with his brother John.

Berne, one of the most estimable and illustrious figures in the annals of medicine, writes to William Hunter in 1764, sending a copy of his physiology, and refers to Hunter's dispute with the Monroes, in a spirit wholly above the littleness of controversies for priority : "He thinks himself happy in having such an able man of his same opinion." He goes on to speak of Hunter's unpublished work on the uterus ; he "longs after your performance of the fœtus whereof he would make a great usage."[1]

It is right to mark the failings even of the great, and this jealousy for the fame of a discoverer is one. Far better was the reply of Watt, when a friend regretted that another should have carried off the honour of discovering the composition of water : "It matters not whether Cavendish discovered this or I : it *is* discovered."

The dispute between the brothers Hunter, often alluded to, occurred in 1780, three years before William's death, and when his health was failing from gout. John had read before the Royal Society a paper on the placenta, in which he stated as his own discovery the determination of the separate maternal and fœtal circulations in the placenta. The work had been done twenty-five years before in William's dissecting room, and had been repeatedly and habitually put forward by the latter during many years past as his own discovery. For what reason John now revived this matter of ancient history and laid claim to the credit himself is not known. William promptly and emphatically protested in a letter to the Society ; and John replied in a cavalier tone, proposing that they should share the honour with all who were present when the dissections were made. The truth probably lay in some sense on both sides. The two brothers working in William's dissecting room, John, under William's directions, made discoveries. William may easily have regarded these as belonging to himself, and his obligations covered by a general acknowledgment of John's able assistance,[2] whilst the latter was disposed to claim them for himself.

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1 Hunter-Baillie MSS. I. 114. Also Memorial of his death, ib., p. 158, "*pie et placide . . . obdormivit in Domino.*"

2 Such acknowledgment was often generous : he would say, "I am simply the demonstrator of this discovery : it was my brother's." Adams, p. 124.

The sharp controversy between these brothers, both so eminent, must have painfully impressed their friends, although the blunt, rough manner of the one and the sensitive pride of the other would go far to account for its occurrence. The Society decided not to print the paper, as it was in dispute. A sad estrangement resulted between William and John, and they scarcely met again.

After Haller died, Hunter was chosen in 1782 to occupy his place as one of the eight foreign Associates of the French Academy, one of the highest honours that a man of science can win. Haller's seat had been occupied before him by Morgagni, and before Morgagni by Ruysch. On this occasion the Chymists, one of the eight classes into which the Academy was divided, wished to have Bergman, the Swedish chemist, elected, but the class of Anatomists insisted that it was their right to appoint a foreign Associate, and Hunter was chosen.[1]

A letter announcing Hunter's election as a Member of the Academie de Medicine in 1778, in succession to Linnæus, bears the signature of Vicq d'Azyr.[2]

We do not find that either Dr. Hunter or his brother took much part in the political events of their time. A letter to a friend written in 1778, five years before his death, concludes: "I told you that I have taken my leave of Politics; and am sorry to say that as far as I am a judge this country deserves humiliation, or rather a scourge. God bless you. William Hunter."[3]

The times indeed looked dark and threatening. Great Britain was at war with the United States and with France; Spain was just declaring war against us. The long contest in Hindustan was in its early and more doubtful stages. At home there was trouble and discontent. And who that could have foreseen the prolonged struggles that were to come during nearly forty years, would not have lost heart for the future of our country? Yet through all, the staying power of the Anglo-Saxon race proved equal to the strain. William Pitt became Prime Minister in the year that Hunter died.

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1 MSS. Miss Hunter-Baillie.

2 Hunter-Baillie MSS., I. 160, 159.

3 MSS. Miss Hunter-Baillie.

Ten years before his death, despite his frugal manner of living, Dr. Hunter began to suffer from "wandering gout," affecting, we are told, sometimes the limbs and sometimes the stomach. His bodily powers, strained by incessant exertion which he would not relax, gradually waned, but the spirit was active and undaunted to the end. On the 20th March, 1783, he rose from his sick-bed, against the remonstrances of his friends, to deliver the introductory lecture of his course, an occasion when there was a large and more general audience. Towards the end of the lecture he fainted, and had to be carried from the theatre. He never rose again, but died quietly a few days later, on the 30th of March. John Hunter came to see him again and again in his illness, and gave him needed surgical attention (catheterism). The brothers were reconciled at last. Dividing lines belong to life ; as it has been finely said, "It is death alone which integrates."

He died in peace. Life had had its storms, but the end was calm. "If I had strength enough left to hold a pen," he said to Dr. Charles Combe his executor, "I would write how pleasant and easy a thing it is to die." William Hunter was only 65 years of age, the same age attained by his brother John ten years later ; both died in the fulness of their work, closing a life of strenuous labour. So died their nephew, Matthew Baillie ; so died many other masters in our art, from the days of Sydenham and of Radcliffe down to those of our own Wilson Fox and Andrew Clark. He was buried in the Rector's vault of St. James's, Piccadilly, where his monument stands between those of Sydenham and Richard Bright.

WILLIAM HUNTER AS ANATOMIST.

I propose to place William Hunter before you as an Anatomist, as a Physician, and as a Practitioner of Midwifery.

Firstly then, and especially, as an anatomist, and in this term must be included throughout the work of the physiologist also, then scarcely separated from the sister science. The high place which is to be assigned to William Hunter in the history of anatomy is based upon four claims :—

First : That he was a close student of nature.

Second : That he made discoveries in anatomy.

Third : That he founded a school of anatomy in this city.

Fourth : That he trained his brother, John Hunter.

I will say a few words upon each of these heads.

(1) Very early in his career William Hunter formed the habit of mind which governed his whole after life, and made him an unprejudiced observer of nature. The words of John Hunter are often quoted, "don't think, but try"—yet this close study of nature by experiment was hardly a less feature of the work of the elder brother. At the age of 26, in a letter to his brother James, he speaks of "my dear idol nature, *simplex munditiis*,"[1] and next year to his friend Cullen, he writes as follows :—"Well, how does the animal economy appear to you, now that you have examined it, as one may say, with precision ? I have good reason to put the question to you, because in my little attempts that way, since I begin to think for myself, Nature, where I am best disposed to mark her, beams so strong upon me, that I am lost in wonder, and count it sacrilege to measure her meanest feature by my largest conception. Ay, ay, the time will come when our pert philosophers will blush to find, that they have talked with as little real knowledge, and as peremptorily of the animal powers, as the country miller who balances the powers of Europe."[2]

These are the crude remarks of a young man, yet how well they forecast his maturer thoughts let an extract from one of his lectures show. He is speaking of the middle of the seventeenth century :—"From that time the important doctrine of rejecting all hypotheses of general knowledge, till a sufficient number of facts shall have been ascertained by careful observation and judicious experiment, has been every day growing into more credit."

Observations such as these may seem to us to be commonplace, but they were not so in his day. The painted scaffolding of mere hypothesis, useful doubtless in its day, but which had too long done duty for truth—had too long hidden

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1 Hunter-Baillie MSS. II. 11. 2 Thomson, I. 21.

the solid edifice which was within—had to be pulled down, piece by piece, in those reforming ages; and in this destructive as well as constructive work, William Hunter did yeoman service. His was an unflinching search for truth as it is found in nature. His life illustrates the precept of Bacon that "Nature is only subdued by submission," and that famous saying of Hippocrates, "Science and opinion are twain; the one makes for knowledge, the other for ignorance."—*δυὸ γὰρ ἐπιστήμη τὲ, καὶ δόξα: ὧν τὸ μὲν ἐπίστασθη ποιέει, τὸ δὲ ἀγνοεῖν.*[1]

(2) William Hunter made for himself discoveries in anatomy.

The tubuli of the testis, the ducts of the lachrymal gland, the origin and use of the lacteal and lymphatic vessels, were subjects early investigated by William Hunter, with more or less assistance from John. William described in his lectures from time to time the discoveries that were made, and it was about these discoveries that, whilst John was at the war at Belle Isle and in Spain, William waged his controversial war with the two Monroes. Probably both they and he did good work in these departments of anatomy, though neither were actually first in time to establish new truths.

Congenital hernia was another topic which closely engaged William Hunter's attention. Haller had discovered and described it, but Hunter was the first to expound in detail its formation, in connection with the descent of the testis from the abdomen.

Again, he explained the anatomy of the different forms of aneurysm more perfectly than had been done before his time, and he minutely described the varicose aneurysm, a condition which had hitherto escaped the notice of surgeons.[2]

The discovery of the separate maternal and fœtal circulations in the placenta has already been referred to, as one in which perhaps both the Hunters had a share. Their description of the placental structure was questioned by later

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1 *Nomos.*

2 *Medical Observations and Inquiries*, Vol. I., p. 323; II., 390; IV., 385.

investigators, but it has been justified by subsequent researches, and forms, I believe, at the present day the foundation of our knowledge of placental anatomy.

In close connection with this discovery must be mentioned his researches into the nature of the fœtal coverings. Hunter first applied the name *decidua* to the membrane which lines the gravid uterus, and first described its disposition in that cavity: the decidua reflexa was unknown before his time.[1] The origin of the decidua was long a doubtful matter. John Hunter speaks of it as developed from coagulated lymph or blood, and gives a plate of it under that description. Even William Hunter is made to favour such a view in his posthumous work on the anatomy of the uterus, but the statement occurs, not in Hunter's own words, but in those added editorially by Baillie. Elsewhere in the MS. lectures which have been preserved, William Hunter states most clearly that the decidua is "a lamella of the uterus," "the internal lamellæ of the uterus itself."[2] It is clear, then, as Matthews Duncan shows, that John Hunter was wrong in this matter and William Hunter right.

Indeed, the closer William's own words in his lectures upon this whole subject are examined, the stronger does the impression grow that he had the principal part in the placental discovery.[3] Dr. Teacher tells me that his study of the preparations at Glasgow leads him to the same view, and that "the fulness and accuracy of William Hunter's knowledge of these structures was marvellous."[4]

But the crowning work of his life was the demonstration of the Anatomy of the Human Gravid Uterus. The book was published in 1774, when he was nearly 60 years of age, and contains thirty-four very large plates, mostly drawn by Rymsdyk. The typography is excellent, and is the work of Baskerville, the famous Birmingham printer. Hunter had been collecting materials for this great work for 23 years,

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1 One of W. Hunter's plates of the decidua is still in use in Quain's Anatomy.

2 MS. Lectures, 1775, R.C.S., 42 c. 31, pp. 34-36.

3 Ib., p. 37.

4 W. Hunter displays a charming enthusiasm when he approaches the subject of the placenta. Holding up to his class an injected specimen, he says:—"Now let me set all modesty and all appearance even of it aside, and say here is the finest preparation in the world." MS. Lectures (cited), p. 27. He was extremely careful and jealous over his preparations: "There," he says, "is a fine preparation, and if you let it fall you may just as well knock me on the head, for I shall not be able to outlive it." Ib., p. 39. See anecdote by Dr. Parry, quoted in *Quarterly Review*, Jan., 1897, p. 113; but this was about 1778, when he was old and gouty.

having previously studied the subject in brutes. In 1751 he met with his first opportunity of examining a specimen of the gravid uterus in man ; it was carefully dissected, and the blood-vessels injected, and drawings were made and coloured by an able hand. In the course of some months, the first ten plates of his work were drawn, and were about to be published, when a second and a third specimen came in his way and furnished supplemental plates. He then formed the design of waiting, until, by embracing further opportunities, he might be able to construct a complete work, exhibiting all the principal changes that occur in the uterus during the nine months of gestation.

An admirable and unique series of preparations, from many of which the plates were taken, is preserved in the Hunterian Museum at Glasgow. There are about 400 specimens altogether, besides very fine plaster casts of many of the dissections. The collection has more than a historical value : it illustrates most graphically to-day the anatomy of the uterus and placenta, and proves how truly and fully William Hunter had discerned their structure and relations. And thus, sparing neither time, nor labour, nor expense, after twenty-three years he was able to bring before the scientific world his great work. The text is in Latin and English, in parallel columns. The plates are of much beauty and fineness of execution. They are nearly all of natural size, and are drawn with marvellous fidelity to nature, not allowing, as he tells us, the imagination to vary the actual appearances in order to render the object more useful as a demonstration—in other words they are in no sense diagrams, but as it were photographic in their reality. This will be easily understood by a comparison with Smellie's tables published some years previously.

This "immortal work," writes Matthews Duncan, "is one of the stable foundations of the science and art of midwifery, and cannot fail, in all future ages, to be as valuable and useful as it now is." It was reprinted by the Sydenham Society in 1851.

(3) A chief part of the influence of a great teacher is upon those who come after him. So had it been with Boerhaave : from Leyden, as from a centre of new light, the influence spread forth, so that in the early part of the eighteenth century a large proportion of the medical schools in Europe were led by those whom Boerhaave had trained. The pupils of the Hunter brothers were in a like manner

the leaders of British medicine and surgery at the beginning of the present century. William Hunter's talents as a lecturer were conspicuous. "He was probably," writes his nephew Baillie, not perhaps an impartial judge, yet a writer of much care and precision, "the best teacher of anatomy that ever lived."[1]

"No one ever possessed more enthusiasm for the art, more persevering industry, more acuteness of investigation, more perspicuity of expression, or indeed a greater share of natural eloquence. He was uncommonly ready in his apprehensions, and singularly happy in making others understand what he knew himself. His arrangement of any subject was clear and judicious; he knew how far the attention would reach, and when it was beginning to decline; and he had a most happy talent of introducing anecdotes which might excite, amuse and instruct."[2]

The School of Anatomy which Hunter founded was located in the house he had built, containing his museum, lecture theatre, and dissecting rooms, and was hence called the Great Windmill Street School. It was carried on after his death, at first by Cruikshank and Matthew Baillie, and after them by others, until about 1830. In the list of teachers at this School we find the names of Sir Benjamin Brodie, Sir Charles Bell, Herbert Mayo, Caesar Hawkins, Benjamin Guy Babington. University College was opened in 1828, and King's College in 1831; Bell migrated to the first, and Mayo to the second, and the old School was soon after closed. Its work was done, and Hunter would have rejoiced to see the day of more ample and noble colleges, where science has been taught in a far wider scope. But of these colleges the old private schools, and this of Hunter's in particular, were the forerunners and parents, and they are worthy of parental honour.[3]

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1 Baillie, *Autobiography*.

2 Baillie, *Lectures*, p. 74. The curious story of Mrs. Van Butchell, whose body was embalmed by Hunter, long preserved by her husband, and is now to be seen in the Hunterian Museum, Royal College of Surgeons, will be found in Pettigrew's *Med. Portrait Gallery*, art. W. Hunter, p. 10. See also Sir George Baker's humorous epitaph:—

"In reliquias Mariæ Vanbutchel, novo miraculo conservatas," etc.

"Ab indecorâ putredine vindicavit
Vir egregius, Gulielmus Hunterus
Artificii prius intentati
Inventor idem, et perfector," etc.

Quoted in Munk's *Roll of the Royal College of Physicians*, 2nd. ed., II., p. 216.

3 On the Great Windmill Street School, see a letter by Sir B. C. Brodie, in Thomson, II., p. 740.

(4) The fourth claim of William Hunter to the position of a great anatomist rests upon the influence and training he bestowed upon his more famous brother, John Hunter.

It was said of Sir Humphry Davy that the greatest of all his discoveries was the discovery of Faraday, and so the greatest of William Hunter's was perhaps the discovery of his gifted brother. I would not indeed say, as Professor Gross does, that "if it had not been for William we never could have had John,"—or quote, with Brodie, the claim of Ulysses to the glory of Achilles, *ergo opera illius mea sunt*: because one who reads John Hunter's works must own the marks of an original mind, which would have made its way, and taken its own course, had circumstances been what they might. Yet William's invitation of his brother to London, and his example and teaching during the years when John was his pupil and assistant, must have had a large part in directing John into the line of study in which he achieved such distinction. His was indeed, as Baillie writes, "a bold inventive mind," untrammelled by conventions or traditions, but seeking after truth alone. They were a great pair—*par nobile fratrum*; much of their work was common. We do well to honour them as "the Hunters."

WILLIAM HUNTER AS PHYSICIAN.

In speaking of William Hunter as a physician, I use the latter word in no restricted sense. Perhaps the departments of medicine were not then so strongly marked out from one another: at any rate Hunter took no narrow view of his profession. He began his medical life as an anatomist, practising surgery the while, then he took a physician's degree, and finally devoted himself chiefly to the practice of Midwifery. Nothing, indeed, that came within the scope of medicine in its widest sense was foreign to his mind. He made many contributions to the six volumes of "Medical Observations and Inquiries," published between 1757 and 1812, by that "Society of Physicians" which was the precursor of the Medical Society of London, and is often confounded with it. Hunter succeeded his friend Fothergill as President of this Society. Several of the papers relate to aneurysm, and to his discovery of varicose aneurysm, others to the advisability of operating in empyema when there is no more than a reasonable probability of finding pus, to necrosis of the tibia and the nature of callus, and to rupture of the capsular ligament in dislocations at the

shoulder. There is one very careful and elaborate record of a case of traumatic emphysema, in which the cellular tissue of the whole of the body was inflated with air. The patient was *in extremis*, but Hunter, by suitable incisions, pressing the air out, and stopping the injured thorax, succeeded in effecting a cure. He goes on to expound the nature and functions of the cellular tissue, and the use of punctures in anasarca: these should be very small, rather than large, as he had learned by trial of both these methods, one on each leg of the same patient. He had dissected black cattle, dead of an epidemic disorder attended with emphysema. Some other papers deal with the structure of the symphysis pubis, and the insensibility of tendon.

There are two remarkable papers on strictly medical topics, both written late in life, and communicated to the Society shortly after his death. One records three cases of congenital heart disease. The first was an infant, cyanosed to blackness, which lived 13 days. The pulmonary artery was impervious at its origin, the ductus arteriosus bringing blood to it from the aorta, and the foramen ovale was open: the right ventricle contained scarcely any cavity at all. In the second case, an extremely thin boy, whose legs reminded him of a greyhound or a water fowl, lived to 13 years, subject to syncopal attacks; the pulmonary artery was found to be stenosed, barely admitting a small probe, and the ventricular septum was partly deficient. This latter condition obtained also in his third case, a still-born infant.

In commenting upon these cases, he enters on the philosophy of malformations and makes the following remarks: "The last conjecture which we shall venture to make is upon the scheme which the Author of our nature has laid down for perpetuating animals. Particular evils are allowed to exist. Many animals, from the imperfection of their fabric, are necessarily to perish before the common natural period. This is compensated for by a great superfluity in the number, and so it is also in the Vegetable Kingdom. As in vegetables too, the parent generally produces a species very like itself: but sometimes a different constitution, whether better or worse. Whatever may happen in a particular instance, or with regard to an individual, the most perfect and sound animal upon the whole, will have the best chance of living to procreate others of his kind: in other words, the best breed will prevail: and the monstrous constitution, and that which is defective, or of such a fabric

as necessarily to breed disease, will be cut off. The most perfect constitution will be preserved: it will be most susceptible of love, and most likely to meet with a warm return of that passion: so that, in every way, the sound constitution will have the preference in procreation, and the defective, weak, or diseased line will be wearing out."[1]

In these remarkable sentences we see a foreshadowing more than 100 years ago of the doctrine of Evolution. The essential influence of Natural Variation and the Survival of the Fittest, two of the most prominent features of the Darwinian theory, are clearly stated by William Hunter.

The other paper is not less noteworthy.

It treats of "the successful cure of a severe disorder of the Stomach by Milk taken in small quantities at once."[2] A boy of seven or eight years was reduced to a desperate condition on account of vomiting his food. He was wasted to a mere skeleton, and had been in the hands of many doctors. Hunter hit on the happy expedient of giving milk alone, and reducing the dose to such a modicum as he could retain. This case is often quoted, and is given at large by Sir Thomas Watson in his lectures.[3]

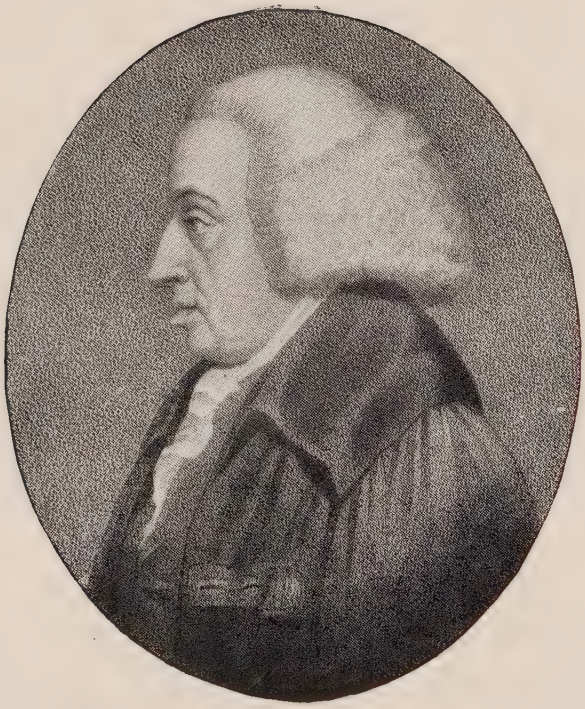
I must allude to one more of Hunter's papers, that on the "Uncertainty of the Signs of Murder in the case of Bastard Children." This paper, which shows that legal medicine also engaged his thoughts closely at times, deals with the delicate and difficult question of the guilt of a mother for child-murder or concealment of birth, and of the proofs of her crime. Hunter's long experience and wide knowledge of mankind, his high sense of justice, and his deep sense of pity are alike displayed in this remarkable paper, which is well worthy of study at this day.[4]

WILLIAM CULLEN.

It may be appropriate here to say something of two eminent friends of William Hunter, William Cullen and John Fothergill. Cullen has already been alluded to as his early preceptor in medicine, and throughout life his constant and affectionate friend. He was eight years Hunter's senior, but he attained a much greater age, outliving Hunter by seven years. It is hardly necessary to describe the high

1 *Med. Obs.*, VI., 307. 2 Id. p. 310. 3 *Lecture* lxviii.

4 *Med. Obs.*, VI., 266. This paper was reprinted in the third edition of Dr. Samuel Farr's "*Elements of Medical Jurisprudence*," 1815. An exquisitely written MS. copy is in the Library of the Roy. Med. Chir. Society.



William Cullen.

position attained by Cullen as a medical teacher. He lectured from 1746 to 1790, for the first ten years at Glasgow, and afterwards at Edinburgh. His fame as a lecturer was very great and well deserved. We are interested here in the comparison between Cullen and Hunter. Closely attached as they were, and consulting together often by letter, their aims in medicine differed somewhat widely. Cullen was of the philosophical school: he took medicine as it was then known, and threw it into systematic shape. He probably did not add, writes Sir William Hamilton, "a single new fact to medical science." By the medium of his lectures, delivered extempore, the principles of the medical art were promulgated in an ordered form and sequence which was evolved by his clear and able mind. Such a teacher must pass over inconsistencies and difficulties, must adopt hypotheses, and can scarcely avoid giving them the emphasis of proven facts, and cannot use that suspension of judgment in matters as yet undetermined which was the attitude of the Hunters. His system, his methodical synopsis of medical knowledge, was admirable for teaching purposes, but its rigid lines tended afterwards to cramp and hinder the very science which at first they promoted; and the greater the ability with which a system has been framed, and the higher its consequent authority amongst men, the longer does it exert its contracting influence over the progress of knowledge.

It was long before Cullen published anything, not indeed until pirated copies of his lectures were being issued by others. When in 1776 he found himself compelled to print, he sent his MSS. up to Hunter in London, begging for his revision and advice. Hunter returned them with a kindly letter.

"I have read them," he writes, "with care, and shall speak with freedom. I am sensible of no material objection to your doctrines. I have not yet made up my mind about many of the phenomena, particularly about inflammatory crusts, exsudation, pus, expectoration, etc., and, therefore, I cannot in some of these questions decide with you or against you."[1]

John Hunter had not yet laid down what has been termed by Latham the grammar of inflammation. A methodical teacher like Cullen *must* make up his mind on all these

1 Thomson, I. 559.

points, and it is not always to the furtherance of the truth. His systematic works continued to be used as text books for at least forty years after his death.[1]

JOHN FOTHERGILL.

Another friend of William Hunter's was Dr. John Fothergill. There was something of a parallel in the outward course of their lives. Each came up to London as a young man unknown, Hunter from Scotland, Fothergill from the Yorkshire dales; each set himself to a life of continuous work and research, each attained to fame and honour and large emoluments, and each died unmarried about the same age.

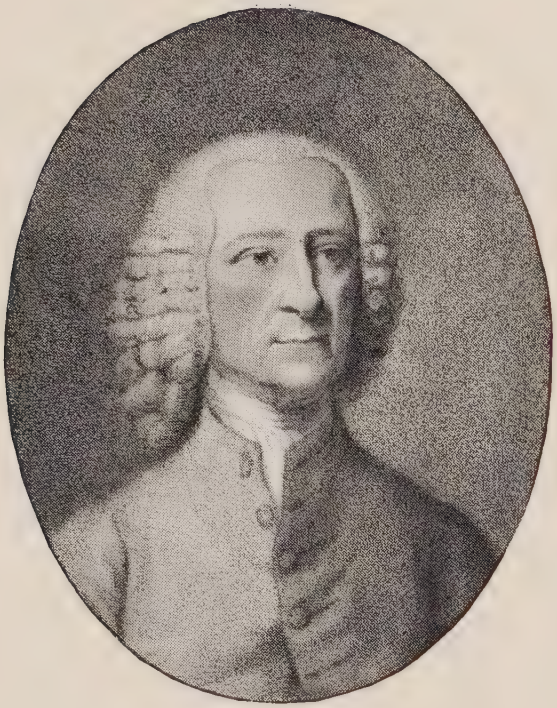
Fothergill was an assiduous and zealous clinical worker: he lived first in Gracechurch Street, and afterwards in Harpur Street, Bloomsbury. His opportunity came in the epidemic of "putrid sore throat" as it was called, which broke out in many parts of Europe in the years following 1747; it is generally considered to have been identical with the "diphtheria" of Bretonneau. Fothergill studied this disease minutely, and was very successful in its treatment. His practice as a physician at once rose, until he could hardly meet the demands made upon him. His treatise upon the disorder is one of our British medical classics.

He was a consistent member of the Society of Friends, a Quaker of the old school, subdued in spirit, cautious in expression, singular in speech, benevolent towards all men. He was Clerk of the Friends' Yearly Meeting one year, and he devoted time and thought, in conference with Dr. Franklin, to draft a scheme for overcoming the dispute with the American colonies without recourse to war.

In a day when good schools were uncommon, he took the chief part in founding a large school at Ackworth in Yorkshire, where his memory is still lovingly cherished; a school which has done excellent work, both within its own community and beyond its borders.

Fothergill had this especially in common with William Hunter, that both were ardent lovers of natural history. The vegetable kingdom was perhaps his chief field. His botanical garden at Upton was esteemed the best in Europe after that at Kew, and was stocked with the choicest plants from abroad. He had agents in every part of the known world collecting new and rare living specimens. A letter

1 Thomson's edition of his works is dated 1827.



John Fothergill.

has been preserved which is said to be in the handwriting of the young Queen of George the Third. It is dated from Richmond Lodge, Sept. 11th, 1769, and runs thus :—

"Mrs. Schwellenberg's Compliments to Doctr. Hunter and she heard yersterday that Doctr. Forthergyll had got several Tea Trees Come from the Indieas in the Last Ships and the Queen wishes that Doctr. Hunter Could make Interest with Doctr. Forthergyll to get Her only one of them for Her Majestys own Garden."[1]

Fothergill died a few years before Hunter, and seventy mourning coaches followed the body to its sequestered and beautiful resting place at Winchmore Hill. His collection of paintings of flowers and other natural objects on vellum was purchased for the Empress of Russia for £2,300 ; and his shells, corallines, insects, reptiles, etc., were offered at his express desire to his friend William Hunter for the sum of £1,500, far below their cost, and they now form part of the Museum at Glasgow.

MATTHEW BAILLIE.

In considering Hunter as a physician it is natural to think of his nephew, Dr. Matthew Baillie. He was the only son of Dorothy Hunter, who married the Rev. James Baillie, afterwards Professor of Divinity at Glasgow. His father dying whilst he was still a youth, young Baillie was adopted by William Hunter, who, however, treated him with a certain strictness which was no doubt judged expedient for his training. He gave him an excellent education, first at Glasgow, then at Oxford, and finally in London. Classical exercises formed an important feature ; he had to send to his uncle from time to time long passages of Latin prose of his own construction. The details of his study were supervised by William Hunter ; he was kept well in his place, and rather "pinsh'd for money." "First deserve, then expect" was his uncle's emphatic injunction.[2]

When he came to London, about three years only before his uncle's death, he became at once his pupil, availing himself at the same time of the best facilities for studying elsewhere. Baillie entered quickly into the Hunters' methods, his training had already made him accurate and methodical, and when Hunter died in 1783, the young man of twenty-two stepped at once into his place, and, in conjunction with

1 Hunter-Baillie MSS. Vol. 1. 2 Ib. II., 4, 21, etc.

Cruikshank, advertised the continuance of the anatomical lectures. It was a bold step, but well justified by the result.

William Hunter had left him his house, and the use of his fine museum for twenty years, after which it was to go to Glasgow. Of the £19,000 which constituted his uncle's fortune, £8,000 was bequeathed for the support of the museum, and other sums as annuities to relatives, so that a comparatively small residue came to Baillie, besides the old Hunter property at Long Calderwood, which he generously relinquished in favour of his uncle John.

Baillie's classes were soon well attended, and for sixteen years he worked assiduously as a medical teacher, dissecting, comparing, lecturing and writing. Morbid Anatomy was his chief occupation, and his steadfast aim was to make this the basis of his clinical work. In the meantime he had been elected, partly through John Hunter's influence, physician to St. George's Hospital. By the year 1800—he was then but 39 years old—his private practice had so greatly increased, that he retired, first from the lectureship and then from the hospital appointment, and devoted himself to his consulting practice alone. This was probably the largest known in London since the days of Mead. He enjoyed the leading position for about twenty years, and was the trusted attendant of King George the Third and his family, and their confidant in their secrets and troubles, which were many. A baronetcy was offered to him about 1812, but he preferred, it would seem, to remain with Harvey and Sydenham and Mead and the Hunters, undistinguished by the titles which have given to some lesser men a brief and borrowed lustre. Like his uncle, Matthew Baillie was a man of slender frame, never robust; his sisters lived to nearly 100 years, and his own life might have been longer had it been one of less pressure, but under the unceasing toil, sixteen hours daily, his mind was harassed and his energies exhausted, so that he died, literally worn out, in 1823, at 62 years of age. He was a man of singular integrity, and guileless simplicity of character, and so bore himself through all the duties of life, which were in his case fraught with wide influence on others, as to win the confidence and admiration of all men.[1]

I have yet to speak of one notable event in Dr. Baillie's life—his publication in 1793 of a treatise on Morbid Anatomy. I think that the importance of this event as

1 See *Memoir* by his son, in *Hunter-Baillie* MSS. II., 80. His *Autobiography* was edited by Mr. J. B. Bailey and published in the *Practitioner* in 1896.

marking an era in the history of medicine is hardly yet appreciated. It was, so far as appears, the first systematic treatise on Morbid Anatomy that had been written in any country. Morgagni in his famous work, *De Sedibus et causis Morborum*, published in 1761, had given to the world a series of records of cases and dissections which forms a storehouse of facts. Soemmerring had done similar work. But Baillie for the first time took the various organs of the body *seriatim*, and set forth the diverse morbid conditions which were found to belong to each. The basis of the work was his own observation, his own specimens and preparations, and those which his uncle had made before him. And the whole was written with such candour and simplicity and clearness of diction, as to be a model for all future writers in the same field. When he does not know the cause of any lesion he does not hesitate to say so: here are no hypotheses to mislead, no traditional maxims which will one day have to be unlearned. Well might the Pathological Society at its origin in 1846 place the bust of this first of British pathologists upon its seal. And well justified are those words which grace his monument in Westminster Abbey, "*Qui ad certiorem rationis normam, eas anatomiæ partes, quæ morbos spectant, primus redegit.*"

Brodie, writing at least fifty years after its first issue, states that Baillie's work "is still the most valuable textbook on that subject that exists . . . It is perfect as far as it goes."[1]

I do not know that it would be possible to illustrate in a more striking manner the place and influence of the Hunters in the development of Medical Science than by contrasting two works, issued at but thirty years interval. Let us take Gaubius's Pathology, the work of a man accounted a leader—he succeeded his master Boerhaave at Leyden—and he was even a reformer, so that he excuses himself in his preface for the innovations he has made. It was published in 1761, and is an able book, yet full of vague generalities and ideas which have come down by tradition. And these are his closing words, "Unless I am mistaken his authority will remain to Hippocrates, credit to Galen, strength and order to Nature."—*Ni fallor, Hippocrati auctoritas sua constiterit, Galeno fides, naturæ virtus et ratio.*

1 Autobiography, p. 137.

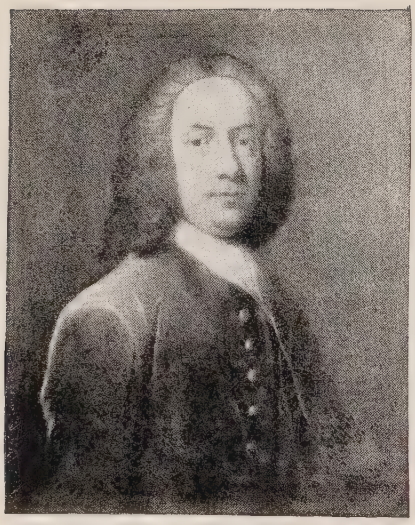
Compare with this Baillie's Morbid Anatomy, issued in 1793. To pass from Gaubius to Baillie is like going out of darkness into light. And this advance in Medical Science, fruitful presently in better medical art, was due, as I submit, mainly to the Hunters, whose anatomical and physiological work Baillie continued and carried into the domain of pathology and medicine.

WILLIAM HUNTER AS AN OBSTETRICIAN.

The art of midwifery was passing in the middle of the eighteenth century through a severe struggle. When Smellie settled in London in 1739 the bulk of the practice was in the hands of midwives. Mrs. Nihell, of the Haymarket, who afterwards published a treatise on the subject, had a large practice, and was a doughty and uncompromising champion of the exclusive right of her own sex to practise the art. Between her and Smellie, who lived hard by in Pall Mall, there was unceasing war. There were indeed men physicians devoted to this art, but when they were called in it was often only to advise the midwife, the patient not permitting herself to be touched. When William Hunter attended the young Queen of George III. he merely waited in an ante-room in case the midwife needed his assistance. The principal men-midwives when Smellie and Hunter began to work were Dr. Maubray and Sir R. Manningham. Of the former it need only be mentioned that he stated a decided preference for a seven months' over a nine months' gestation, on account of the influence of the moon and the mystical value of the number seven. Manningham was of a better order, and long enjoyed a high reputation in London, where he founded the first maternity institution. He detected the imposture of Mary Tofts, the "rabbit-breeder." Yet so far was the art in its infancy that in his compendium, published in the year that Smellie commenced practice, no mention is made of any sort of instruments. Instruments, however, were in use, but mainly of a destructive kind, and it was Smellie's earnest desire to find better methods, so that in difficult cases the child's life should not be sacrificed, that brought him to London.

WILLIAM SMELLIE.

It will be convenient to say a little more here of William Smellie, who has found in recent years so excellent a *vates*



William Smellie.

sacer in Dr. Glaister, to whose work I am indebted for much information.

He came from the same county as the Hunters and Cullen, having been born in Lanark some twenty years before William Hunter. Engaged at first in general practice in his native town, he took a keen interest in midwifery work, and came to London, as has already been said, to seek for improvements in his practice and methods. He went to Paris to Gregoire, then in much fame, but he was disappointed in him and in the other French teachers. Smellie settled in London in 1739, and practised and taught midwifery to large classes. His success was great; he had mechanical genius, and he studied the use of the forceps, then newly invented by the Chamberlens, until he had mastered the subject. He was the first writer to lay down rules for the safe application of the forceps, and as such is entitled to the gratitude and honour of all men. William Hunter, who was conservative in his midwifery practice, discouraged its employment, although he probably used it sometimes; he would say that he rather regretted the invention of the instrument, as he thought it had done more harm than good. Partly in consequence of Hunter's teaching, the use of the forceps, which had obtained a good deal of currency in Smellie's time, fell into disfavour towards the end of the eighteenth century, until Baudelocque and others restored it to its rightful place.

Smellie was uncultured, and unpleasing to those of polite manners, so that he never acquired large practice amongst the upper classes, skilful practitioner though he was. He tells us that in one labour, "I sweated so much that I was obliged to throw off my waistcoat and wig, and put on my nightgown, with a thin napkin over my head." I know not how far our leading obstetricians of to-day would regard this as a dignified costume. William Hunter, on the other hand, was urbane and conciliatory, and was singularly calculated for the practice of midwifery, Baillie tells us, "by the delicacy of his manners, and a very quick perception of the caprices of the world."[1]

Smellie retired from London to end his days quietly in Lanark, (where the battered remnants of his library,

1 *Lectures*, p. 75. Compare the "Eloge" upon W. Hunter in the Académie Royale des Sciences. "Il fut très-heureux pour les Dames Angloises, que M. Hunter unit à une habileté pour le moins égale, la douceur et les agrémens dont l'austère et savant Smellie avoit été privé," quoted in *Memoir of Smellie, New Syd. Soc.*

bequeathed for the benefit of the town, are still to be seen), revising his collections of cases, and publishing them to the world. For some years before this, he and Hunter, once intimate, had somewhat diverged, and Hunter tried in vain to arrange an interview between them before the former departed. Smellie avoided it, and wrote a curious letter from his Scottish retreat to Dr. Clephane, a mutual friend, to explain his reasons, quaintly dating his epistle from Tartarus, and addressing those still in the land of the living. He was evidently afraid of Dr. Hunter, whose quick wit and "glib tongue" would soon get the better of a silent man, without any conversational powers outside his professional work. He sent also a "letter of exculpation," a very singular and candid description of his own character.[1] Smellie was a great practitioner and an admirable man, and probably furthered the progress of his art more than any other single man in his century.

William Hunter was for many years the acknowledged leader in obstetric practice in London. In dealing with his claims to distinction in this department, I am glad to be able to quote one who wrote with authority, the late Dr. Matthews Duncan. In his "Researches in Obstetrics" (1868), Dr. Duncan quotes Dr. Hunter many times; for example :—On the inclination of the axis of the uterus, the plasticity of the uterus adapting itself to the shape of the fœtus, the condition of the cervix during pregnancy, the cause of the fœtal head being commonly downward, the especial development of the cephalic end of the fœtus, the posture of the child during the last months of gestation, the early implantation of the placenta over the cervix, the separation of the fœtal from the maternal portion of the placenta in a four months' conception, and the operation of symphyseotomy.

Smellie acknowledges the help derived from Hunter's "reforming the wrong practice of delivering the placenta," *i.e.* leaving it more to natural efforts. And Hunter's lectures, preserved to us in the notes of students, bear witness to his thorough grasp of the practical issues of his art. He describes for instance, clearly and simply, the occurrence of fever, convulsions, white leg, hemiplegia, etc., in the puerperal

1 See the letters, discovered by Prof. J. Young, M.D., *Brit. Med. Journal*, 1896, II. p. 514. A short letter from Smellie to W. Hunter is in the *Hunter-Baillie* MSS., I. 110.

state, and his treatment, if rather conservative and inactive, is at any rate free, alike from active hurtfulness, and from a pretence of specifics.[1]

Hunter described the retroversion of the gravid uterus apparently for the first time, and proposed the name by which the displacement is now known. His papers on this subject are very clear and interesting.[2]

WILLIAM HUNTER'S PERSONAL CHARACTER.

A few words remain to be said on William Hunter's personal character. His many-sided tastes have been referred to. It is wonderful, perhaps, that they did not hinder him from attaining high distinction in his own profession. But he had no wife nor child, and his museum was the recreation of his leisure hours. A man of untiring industry, an early riser, exact and orderly in his habits, thoughts and speech, he combined the learning of a scholar with the refined manners of a gentleman. He was kind, and he was just: and if he was so conscious of his own abilities, and so sensitive to praise or blame, that he sometimes appeared jealous, sometimes even bitterly combative in his attitude to others, such feelings did not long disturb his peace of mind. "I am I believe one of the happiest of all men," he writes to Cullen in 1768, "though my hurry is somewhat greater than I could wish."[3]

Of the vein of quaint humour which pleasantly varied the course of his lectures, I may give one illustration. It was in 1775, at the close of the session—he was approaching his sixtieth year: "I have now finished," he said, "twenty years of lectures. However, as I presume I am still approved of, I propose twenty years more to begin next October, and after this is over, I propose to settle in the world and take to me a wife."[4]

He was one who

> "preserved from chance control
> The fortress of his 'stablisht soul;
> In all things sought to see the whole;
> Brooked no disguise;
> And set his heart upon the goal,
> Not on the prize."[5]

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1 M.S. Lectures R.C.S. 42. b. 34. 2 *Med. Obs.* IV. 400, V. 388.
3 Thomson, I. 4 M.S. Lectures, 42, c. 31.
5 W. Watson on Matthew Arnold.

I have thus sought to set William Hunter before you as a great anatomist, and as a sound and successful practitioner of medicine and midwifery.

"Verax : capax, perspicax : sagax, efficax : tenax."[1]

A teacher of renown and wide influence, he contributed greatly, with his brother John Hunter, to establish medical science and art upon the only sure foundation, that of anatomy. May we not rightly speak of "the era of the Hunters," and associate the two brothers together in the great work they did for natural science ?

EPOCH OF HUNTER'S DEATH.

Time will not admit of more than a brief allusion to the epoch of William Hunter's death in 1783. It was a period of intense mental activity, and science was advancing with giant strides. Already his friend, Sir Joseph Banks, had entered upon the forty-two years' tenure of the chair of the Royal Society, where he was surrounded by a constellation of genius, every man taking rank as a discoverer of some great new fact or law in Nature. The modern science of chemistry was being rapidly evolved. Joseph Black, Cullen's pupil, had long discovered latent heat, Priestly had lately found oxygen ; Lavoisier was also at work, and air and water had just been resolved into their elements by Cavendish. The determination of colour vision by Dalton, and Rumford's investigations on heat followed soon after. Hunter's friend Franklin had discovered the properties of atmospheric electricity, and animal electricity and the nature of currents were now coming to light by the labours of Galvani and Volta ; but Faraday was yet unborn, and few of the secrets of this wonderful science had yet been revealed. Thomas Young and Wollaston, future leaders in physical science, were mere youths, and Humphry Davy was in the nursery. Mechanical applications of the laws of Nature were keeping pace with their discovery. Watt had already invented the steam-engine, and five years after Hunter's death it was applied to navigation by sea, whilst Erasmus Darwin, with the prescience of genius, was singing of its employment for locomotion on land. Herschell meanwhile was bringing to sight distant worlds and moons, by means of his giant refractors.

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1 Dr. John Brown, "*Locke and Sydenham.*"

Nor was it less an epoch of large political changes. The American colonies were separating themselves on the one hand, and on the other Governor Phillips was effecting the first settlement on the Australian continent. The French Revolution, like a dark cloud overhead, was about to explode with thunderclap upon astonished Europe. The year 1769, that year of momentous births, was passed, and had given to the world Bonaparte, and his Generals, Ney and Soult and Lannes; Mehemet Ali of Egypt, our own Wellington, Sydney Smith, Brunel, Humboldt, Sir Thomas Lawrence, and William Smith, the father of English geology.

The science upon which our own art is founded is in its turn built upon the physical sciences, and changes such as have been alluded to, influenced, more slowly perhaps, yet surely, the practice of medicine. The invention of the stethoscope by Laennec soon after this date revolutionised one department of medicine, as did later on the adaptation of the microscope to medical purposes, by the discoveries of Selligues and of J. J. Lister (father of Lord Lister).

The Brunonian system had its rise at this epoch, and lived its little day. Vaccination was discovered by William Hunter's pupil, Jenner, thirteen years after his death. The great Hunterian pupils, Abernethy and Astley Cooper, Anthony Carlisle, Cline and Clift, Macartney of Dublin, Physick of Philadelphia, were mostly boys at school. So were Henry Halford (Vaughan) and Charles Bell.

So full was the world of new thoughts and new knowledge, thus instinct with life and progress were the natural sciences, and such was the promise of the future, when the Hunters, who had done so much to lead men to the pure study of Nature, were passing away. Their work in biology had made the discoveries of others possible: for each generation, stepping on the shoulders of that which went before it, attains to heights that were as yet unknown. That we may not forget the great men who have gone before, but may remember how the precious heritage of our knowledge has been bought for us by the strenuous toil of giants in the past, is the purpose of orations such as this. And it is with that aim that I have brought before you this evening William Hunter, a man "by his life and by his art worthy of honour from all men to the end of time."—*καὶ βίου καὶ τέχνης, δοξαζομένος παρὰ πᾶσιν ἀνθρωποις εἰς τὸν ἀεὶ χρόνον.*[1]

1 Hippocrates, *Oath.*

BIBLIOGRAPHY, ETC.

It only remains for me to express my acknowledgments to those who have kindly rendered me assistance in preparing this oration. And firstly, to the Council of the Royal College of Surgeons, for permission to use the rich stores of the Hunter-Baillie Manuscripts, coupling with this the name of Mr. J. B. Bailey, B.A., the Librarian, whose interest in the Hunters is well known.[1] Miss Hunter-Baillie's kindness in giving free access to all documents remaining in her own hands deserves a warm acknowledgment : well were it if all the family records of the great found such worthy and public-spirited custodians. To the learned Curator of the Hunterian Museum, Glasgow, Professor John Young, M.D., I have also to tender hearty thanks, as well as to the Under Keeper, Mr. John Young, LL.D., and to the Assistant Curator of the Pathological Department, Dr. John H. Teacher, for many references. Several other gentlemen have kindly afforded advice or information, amongst whom I may mention Sir James Paget, Dr. William Munk, and Mr. J. Hutchinson.

Dr. William Hunter's life was written in the year of his death by Dr. S. F. Simmons. There are also good articles in various Encyclopædic works, especially in the National Dictionary of Biography, in Dr. McMichael's "Lives of British Physicians," and "The Gold-Headed Cane," Dr. Munk's "Roll of the Royal College of Physicians," and Dr. Pettigrew's Medical Portrait Gallery. Sir Benjamin C. Brodie delivered the Hunterian Oration on William Hunter in 1837, but Dr. Matthews Duncan's Harveian Address in 1876 (see *Edinburgh Medical Journal*, June 1876) gives the best and most appreciative account of his life and work. Dr. Duncan's "Researches in Obstetrics," 1868, are also full of allusion to W. Hunter. The late Dr. Mather's life of W. Hunter in "Two Great Scotsmen" is almost entirely a compilation from Duncan and Simmons. A valuable series of William Hunter's letters is printed in Thomson's life of Cullen, and both in that work and in Glaister's Memoirs of Smellie, there is much information concerning Hunter. Several of Baillie's works contain important allusions to his uncle. And the lives of John Hunter, especially Adams's and Ottley's, should be consulted. Other authorities have been cited in the text.

William Hunter's own works are not numerous. Besides the plates of the "Gravid Uterus," 1774, and the posthumous work on its anatomy, edited by Baillie, 1794, there are his "Medical Commentaries," 1762, and "Two Introductory Lectures," 1784. Many of his papers are contained in the six volumes of the "Medical Observations and Inquiries," and others on anatomy and zoology are in the "Philosophical Transactions." Of the London medical libraries, that of the Royal College of Surgeons is rich in MS. copies of Hunter's lectures, written by his students : some are of great interest ; other excellent copies are in the Library of the Royal Medical and Chirurgical Society, and some in that of the Royal College of Physicians.

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1 Alas, that death has now removed him from us.

HUNTERIAN SOCIETY.

FEBRUARY 26th, 1896.

KNOWSLEY THORNTON, ESQ., M.B., C.M., delivered the first Hunterian Society's Lecture, on

"THE LINES OF ADVANCE IN ABDOMINAL SURGERY,"

a full report of which will be found in the *British Medical Journal* of February 22nd, 1896.

At the close of the lecture MR. CHARTERS J. SYMONDS proposed, and DR. DAVIES seconded, a hearty vote of thanks to Mr. Thornton for the very able and instructive lecture he had given to the Society.

MARCH 11th, 1896.—Pathological Evening.

INTRODUCTORY ADDRESS BY THE PRESIDENT.

The PRESIDENT said :—Before proceeding with the business of the evening, I ask permission to thank the Society for the honour it has done me by electing me as its President. This Society has had a long and honourable past. Its roll of past Presidents includes men of the highest eminence in our profession. I do not think I can better express my desire to be useful to the Society than by saying that I shall keep the example of my predecessors in this office before me, and try to serve the Society, if not with the ability, at least with the diligence that they did.

The peculiar features which the Hunterian Society has cherished as its own are good and pleasant ones. I take them to be the absence of formality, and the encouragement of good feeling. Our motto, "Ratio Societatis Vinculum,"

reminds us that we are bound together by a common wish for truth, and a common expectation of learning from one another. We fetter discussion by no restriction. We come here to learn : but willing, if we can, to teach in return. That this end may be attained, we fetter discussion by no restrictions, nor do we limit the freedom of those who put original work before us : they can re-publish it where and when they like. In our clinical and pathological evenings we imitate Hunter in his love for specimens : we prefer things to thoughts : seeing and handling things to hearing about them.

The present is an age of specialism. In Societies devoted to special subjects, a meeting often consists of experts talking to experts about small points of detail. This is not what we wish at our Society. Our Society is not only composed, but chiefly worked, by general practitioners. A general practitioner is a specialist : and his special department includes matters of the highest importance. I hold that the training of no medical student is complete unless he has spent some months—a year is not too much—as assistant to a general practitioner. In that capacity he may learn much that he cannot learn in any other way.

A general practitioner is a specialist in small ailments. Many grave diseases begin with slight symptoms. The recognition of these in their early stages is the business of the general practitioner. If he fail in this, often his patient will first learn the nature of his disease when it is past cure. Sometimes the patient will over-estimate the significance of some trifling phenomenon : and then it depends upon the general practitioner by correct diagnosis, both as to mind and body, to save the patient from becoming the prey of quacks. Even when no such issues as these depend upon the knowledge and skill of the general practitioner, circumstances compel him to study and treat many small complaints which trouble patients, especially those of the unoccupied class, to an extent not understood by those whose experience is limited to hospital patients.

The general practitioner is a specialist also by reason of his special knowledge of his patient and his patient's surroundings. The consultant may know the disease, but the general practioner knows the patient. I will relate a case in illustration. I once saw a lady who had been attended for years by an honoured Fellow of this Society. She had removed from his neighbourhood, which prevented her from continuing to have his regular attendance. She, therefore, being ill, called in a general practitioner close at hand, an able and well-informed man. He found the patient with a big, tympanitic, painful, and tender belly, a temperature of 101, pulse of 140, and incessant retching. He diagnosed peritonitis. Some hours afterwards I saw her with him, and could only concur in the diagnosis, although it struck me that the patient had not the pinched, anxious expression usual in peritonitis. Next day we met her old medical attendant, who joined to his general knowledge a special knowledge of that patient. He said, "I don't think she has peritonitis. I have seen her like this many times before. She has over-eaten herself, and a good purge will put her right." The purge was given, and the patient got well.

The general practitioner has a knowledge of the whole circumstance, habits, feelings, and wishes of his patients that enables him to take a juster view of the effects of disease and of treatment than any one can do whose knowledge is limited to a particular part of the patient's body, however accurate that knowledge may be. His continued knowledge of his patients' lives acquaints him also with the ulterior results of treatment, information which the specialist in one kind only of disease often finds it difficult to get.

In these ways the special knowledge of the general practitioner is most helpful to those who have to do with diseases rather than patients.

The educational necessity of a period of training under a general practitioner has often been represented. I need not emphasize its more obvious benefits, such as experience in the management of those infectious diseases which cannot

be admitted into hospitals ; acquaintance with details of nursing, diet, prescribing, and dispensing ; and tact in persuading patients for their good. In all these ways I think that a medical man's education is defective unless he has learned that which can only be learned in general practice.

This Society is one of those to which generalists and specialists come together to learn from one another.

As an example of the ways in which general practitioners can help us to correct knowledge hardly otherwise obtainable, take the absurd statements made some years ago by Noeggerath, of New York, and copied into text-books as if they were facts. He said that gonorrhœa in the male was seldom or never really cured ; that it commonly remained "latent" ; and that upon marriage this latent gonorrhœa of the husband destroyed the health of the wife.

It is true, of course, that husbands do sometimes give their wives gonorrhœa, and that gonorrhœa sometimes produces very serious disease in women ; but a gynæcologist sees the women after the gonorrhœa has made them ill ; his knowledge about the date of this disease is only what the person concerned chooses to tell him. He knows nothing of the many healthy, fertile, happy wives whose husbands have had gonorrhœa and been cured of it before marriage.

General practitioners can tell us exactly what we want to know. If some of those who have been for a generation in practice would look over their day books of from 10 to 20 years ago ; note the number of young men they have treated during that time for gonorrhœa, and then note how many of them have married, and in how many the wife's health has suffered ; we should know the truth about this matter. My own opinion is that "latent gonorrhœa" only means neglected or concealed gonorrhœa.

Another thing upon which we want general practitioners to inform us, is as to the results of the marriage of syphilitics. Our present knowledge is gained from the observations of those to whom children are brought because they are suffering from inherited syphilis. Hence the fearful picture of the

result of a syphilitic pregnancy which a lady doctor drew in the British Medical Journal some months back. Consulting surgeons and physicians do not see the healthy children of syphilitic parents. We want observations which begin with the syphilis: not with the children. If general practitioners would examine the records of their practice of years ago: pick out the cases of primary syphilis, and note the treatment, the dates of marriage, and the condition of the children, we should be able to form a more truthful representation of the effects of inherited syphilis than we can at present.

Some of the obscurest problems in gynæcology concern the disorders of adolescent girls, such for instance as chlorosis and dysmenorrhœa. To my mind the conclusion is irresistible that such disorders must be due to conditions affecting development. We know in a general way something of the conditions which favour healthy growth, and those which hinder it. But we know nothing of those which specially affect the development of the blood-making and the reproductive organs. It is impossible for a specialist to whom a patient comes, who till then was a stranger, to go up the stream of time and find out the influences which have made his patient what she is. It is the family doctor who knows the parents, the surroundings and the habits of the patients, who has the best opportunities for the elucidation of these difficult but important questions.

I submit these few remarks to your consideration hoping that they may be of common interest.

STENOSIS OF THE PULMONARY VALVE WITH COMMUNICATION BETWEEN THE AURICLES.

Specimen shown by Dr. Arnold Chaplin.

Dr. Arnold Chaplin described this specimen, taken from a female aged 19. The heart showed well-marked stenosis of the pulmonary valve and communication between the auricles. She had been under observation for six years, and dyspnœa and cyanosis had increased. Then the left apex became flattened and dull, and the expectoration showed tubercle bacilli.

Dr. Chaplin pointed out that in pulmonary stenosis a communication between the auricles rather than the ventricles, was most common. It was also pointed out that some rare cases of pulmonary stenosis terminated in pulmonary phthisis, but not all, the reason being that in the exceptional cases the pulmonary artery is much larger than normal.

FRACTURE OF THE FIRST PHALANX OF THE LEFT FORE-FINGER. RÖNTGEN RAY PHOTOGRAPH.

Case shown by Dr. S. E. Cotman.

Dr. Cotman showed this patient, who in February broke the first phalanx of left forefinger. The finger was put up in a metal splint, but the bone appears not to have been perfectly set. The Röntgen rays were called into requisition (two minutes' exposure), and a clear photograph obtained showing the deformity.

SACCULATED ANEURISM OF SECOND AND THIRD PARTS OF THE ARCH OF THE AORTA.

Specimen shown by Dr. Glover Lyon.

Dr. Glover Lyon showed a specimen of sacculated aneurism of the second and third parts of the arch of the aorta, in which a clot was present which did not quite fill the sac of the aneurism. Dr. Lyon asked whether any of the Fellows had seen any specimen of a cured aortic aneurism. He had seen one when at St. Thomas's.

In the case from which the specimen was taken, the left pulse was larger than the right: the left bronchus was dilated. There was no bronchitis nor pneumonia, but paralysis of the left vocal cord was present. The patient subsequently died of dyspnœa, for which at the P.M. no cause could be assigned.

Dr. F. J. Smith alluded to a case of cured aortic aneurism which had been exhibited to the Society by Dr. Chaplin. Dr. Smith emphasized the fact that aneurism does not cause hypertrophy of the heart, if the valves on the proximal side of the aneurism are intact.

Dr. Arnold Chaplin alluded to a case of aneurism of the aorta with pressure on the left pneumogastric. The left lung was hollowed out into a large gangrenous cavity, which in the absence of other causes was probably due to trophic effects from the pneumogastric nerve.

Drs. Sequeira and Hingston Fox joined in the discussion on the specimens shown by Drs. Chaplin and Glover Lyon.

OBSCURE CAVITATION OF THE LUNGS.

Specimen shown by Dr. Glover Lyon.

Dr. Glover Lyon showed a specimen of cavitation of the lungs, in which the origin was obscure. Was it a case of aneurismal dilatation which had burst into a bronchus: or a pulmonary cavity with a haemorrhage into it, due to rupture of a pulmonary aneurism?

Dr. Charlewood Turner thought the cavity was probably a dilated bronchus into which an aneurismal dilatation of the pulmonary artery had burst.

SCURVY RICKETS.

Specimens shown by Mr. A. H. Tubby.

Mr. A. H. Tubby showed specimens of scurvy rickets. The points emphasized were the separation of the epiphyses and the haemorrhage beneath the periosteum.

Dr. Charlewood Turner asked if the case were one of rickets as well as scurvy, on account of the beading of the ribs.

Dr. F. J. Smith enquired as to the real factor in the causation of rickets.

Mr. Targett stated that he had not seen a case of scurvy rickets at the Evelina Hospital in 9 years. He agreed with Mr. Tubby that the cases of scurvy rickets were really rickets and not scurvy.

Dr. Glover Lyon asked if the case shown by Mr. Tubby was one of bad nutrition of any kind.

Mr. Hoar, of Maidstone, also joined in the discussion.

Mr. Tubby, in reply, stated that such cases were exaggerated rickets and not scurvy.

ADHESION OF THE HYDATID OF MORGAGNI TO THE GREAT OMENTUM.

Specimen shown by Dr. J. H. Sequeira.

The specimen was obtained from a dissecting room subject. From the outer end of the broad ligament a fine cord, seven

inches long, extends to the great omentum. At its upper end is a small ovoid swelling, the hydatid of Morgagni. The band was evidently produced by adhesion of the hydatid of Morgagni to the great omentum, and the subsequent stretching and elongation of the pedicle by the excursions of the great omentum. There was no evidence of peritonitis, and there was no intestinal obstruction.

RARE INTRA-ABDOMINAL BANDS.

Specimen shown by Mr. J. H. Targett.

MR. TARGETT showed the trunk of an anencephalic fœtus with a slender, fibrous cord passing from the root of the mesentery to the umbilicus, which represented the omphalo-mesenteric vessels. In a similar fœtus a cord passed from the left groin to the liver. It was not the round ligament of the liver, but probably an aberrant, deep epigastric artery, which on account of ectopia vesicæ had lost its proper relations to the abdominal wall.

DR. J. H. SEQUEIRA showed specimens hardened in formaline.

SUPPURATIVE EPIDIDYMITIS.

Specimen shown by Mr. J. H. Targett.

Clinical History.—The patient was a man aged 30, who was first seen in October 25th, when he was suffering from a sharp attack of urethral fever, temperature 103°, sweating, etc. The urine contained a large amount of albumen, pus, blood, and epithelium. Three days later the *right* epididymis became inflamed ; the swelling began at the globus minor and extended gradually to the globus major, while the following week acute orchitis supervened. The pyrexia subsided, and the usual local remedies were applied to the swelling, lead and opium lotion, belladonna, fomentations, etc., but it did not disperse. In fact at the end of a fortnight there was more inflammation in the scrotum, and the whole swelling became superficially red and angry. Suppuration took place, an abscess was opened, and a considerable quantity of pus was evacuated. This pus was

carefully examined for tubercle bacilli with negative result. The wound in the scrotum rapidly enlarged, and the testis began to protrude in the form of a fungating tumour. The spermatic cord at this time was much thickened, some of the ingirmal glands were enlarged, and *per rectum* the prostate felt indurated, while there was a decided enlargement of the *right* vesicula seminalis, corresponding with the affected epididymis. After this discharge of pus, the scrotal swelling steadily diminished in size, and the glandular enlargement subsided. On November 27th, as the testis had almost become extruded from the scrotum it was removed by operation, along with the adjacent scrotal coverings. From that time the wound rapidiy healed, but the urine still contained a small quantity of pus. The history of the patient showed that three years previously he had suffered from gonorrhœa and *left-sided* epididymitis with orchitis, from which he "completely" recovered. Two years previously he married, and became the father of a fine healthy child. For the last six or eight months of his illness he had had bladder symptoms, frequent micturition during the daytime, dyspepsia, and failing health. But there was no clinical evidence of syphilis, nor tuberculosis of of the lungs, and he had been twice passed "first-class" for life insurance. Yet from the persistence of the vesical symptoms, and the absence of such conditions as stricture or calculus, it was supposed that there might be tuberculosis of the genito-urinary tract.

Description of the specimen.—The preparation as exhibited consists of a right testis with the adjacent portion of the scrotum and spermatic cord. There is a ragged aperture in the scrotum, five inches in circumference, through which the body of the testis protrudes. Close examination shows that the body of the testis is partially detached by sloughing, and that the proper tunics of the testis, viz., the visceral layer of the peritoneum, the tunica albuginea, and the tunica vasculosa, are perforated in several places. These perforations are marked by protusions of glandular substance, the seminal tubules of which can be drawn out in the usual

manner. Some of the protusions are of considerable size, especially that near the lower pole of the organ. The epididymis and spermatic cord are much surrounded by dense inflammatory tissue, but are not involved in the sloughing process. On microscopical examination there is no evidence of tuberculosis in any of these tissues. Hence it appears that the condition here shown was the result of an acute inflammatory process, attended with suppuration, and gonorrhœal in origin. The actual opening in the scrotum began in a surgical incision, but rapidly enlarged, and allowed the formation of a well marked hernia testis. The inflammation in the body of the testis passed on to sloughing, then rupture of the special tunics of the testis, and finally extrusion of the seminal tubules. Though the clinical symptoms were somewhat suggestive of tuberculosis, yet careful examinations of the pus from the abscess, and the tissues of the scrotum failed to show any tubercle bacilli. The specimen is of interest as indicating an unusually severe result of gonorrhœal epididymo-orchitis, occurring in a debilitated subject. The enlargement of the corresponding vesicula seminalis must be attributed to extension of the inflammatory process to that organ, and its limitation to one side (the diseased side) is a point against the tuberculous nature of the lesion. (The specimen is No. 4194A in the Royal College of Surgeons' Museum.)

March 25th, 1896.—Clinical Evening.

SPASMODIC TREMORS SUCCESSFULLY TREATED BY SUGGESTION.

Case shown by Sir Hugh Beevor for Dr. J. F. Woods.

M.C., age 17, had spasmodic tremors of the right hand and forearm for about three years, with an interval of apparent recovery during the first year. The illness was caused by a fright. Sir Hugh Beevor sent this case to me on January 27th of this year. She was shown on the last clinical

Gone by
Train
Carried
a Pocket Book
Please
Return
to
Owner

Jan 30th 6

Mary Emma

Elizabeth Barnett

Scott Hillsboro

4.20 Pm

Jan 31st 6

Mary Barnett

Elizabeth Scott Hillsboro

Mary Bennett
3 Royal Park Place
Frant Hill Road

Mary Bennett
3 Royal Park Place
Frant Hill Road

Feb 4th 96

Mary Coombes
2 Royal Oak Place
Forest Hill Road

Feb 5th 96

Mary Coombes
2 Royal Oak Place
Forest Hill Road

Feb 6th 96

Mary Coombes
2 Royal Oak Place
Forest Hill Road

Feb 7th 96

Mary Coombes
2 Royal Oak Place
Forest Hill Road

Feb 8th 96

Mary Coombes
2 Royal Oak Place
Forest Hill Road

Feb 10th 96

Mary Coombes
2 Royal Oak Place
Forest Hill Road

Feb 14th 96

Mary Coombes
2 Royal Oak Place
Forest Hill Road

Feb 15th 96

Mary Coombes
2 Royal Oak Place
Forest Hill Road

Feb 20th 96

Mary Coombes
2 Royal Oak Place
Forest Hill Road

Feb 29th 96

Mary Coombes
2 Royal Oak Place
Forest Hill Road

evening, and had been treated by chloral and bromide, and her hand was kept for some time in a plaster case, but the movement commenced again soon after it was removed.

I have treated her by short hypnotic sleeps daily, except Sunday, for the first three weeks, and then at intervals until March 8th, when the tremor entirely ceased, and there has been no appreciable return of it since that date. It is interesting to notice the specimens of writing, which show how gradual the improvement has been. (See diagrams.)

LOCALISED HEAD-PAIN AND GIDDINESS TREATED BY SUGGESTION.

Case shown by Sir Hugh Beevor for Dr. J. F. Woods.

S.G., aged 43, had suffered from localised headache and giddiness since August 2nd, when he fell in a fit and was unconscious for about five minutes. For some days previous to the fall he had sensations of giddiness. This case was sent to me on March 11th of this year by Sir Hugh Beevor, after having been for about three months under treatment at King's College Hospital. He had taken the following:—Pot. Iod. gr. x., Pot. Brom., Liq. Morph., Salicine, Am. Chlor. He also had his head shaved at the tender spot and a blister applied. I have seen the patient four times and have treated him by suggestion without hypnotic sleep, the result being that he improved at once, and I think now is nearly well, as he has had no giddiness and scarcely any pain, and feels altogether brighter.

Mr. Grogono enquired if the first patient was the subject of hysteria.

Dr. F. J. Smith enquired if the second patient suffered from sunstroke.

Dr. Glover Lyon asked as to the occupations of these patients, on the ground that no case of hypnotism had become a useful member of society after its employment.

The President enquired if cannabis indica had been tried in the second case.

Sir Hugh Beevor stated that the cases he had sent to Dr. Woods had left the latter's hands much improved in mind and appearance. This was in reply to Dr. Glover Lyon : and further that the second case (the man suffering from headache and giddiness), had done six hours work after he had been treated by hypnotism.[1]

ADDISON'S DISEASE.

Case shown by Dr. F. J. Smith.

The patient, H.H., was a public-house manager at 30, admitted under Dr. Smith's care in the London Hospital on February 20th, 1896, with the following history : No phthisis nor other illness of importance in family. Personally has had no previous illnesses, has partaken of stimulants fairly freely but not to any excess. His present trouble began about three months before admission, and he himself definitely attributes it to a fall in which he strained his chest but did not actually strike it, at any rate it is from the time of that fall that he began to get weaker and weaker and less inclined for exertion. At the same time he began to suffer from rather severe headaches and occasional sickness, especially in the morning : his bowels have been very constipated and he has lost flesh rather rapidly (two stones in three months).

On admission he was found to be very weak and emaciated, and the skin shewed very typical bronzing, especially on some old acne scars, the mucous membrane of lips and cheeks, and over a rectangular area previously covered by a belladonna plaster. The vomiting and nausea, the pigmentation, and above all the exceeding smallness and feebleness of the pulse without indication of organic disease of the heart, pointed conclusively to the nature of the disease, and he was accordingly treated with five grains of

1 May, 1897. This man is at full work.

"suprarenal" powder three times a day. He improved considerably under this treatment, so much so that on March 30th he was allowed to go out to the seaside.

The weather at the seaside proved very treacherous and unfavourable, and the patient soon went back in health and was re-admitted on the 11th of May, 1896, and sank rapidly, dying on May 25th. Notwithstanding that the suprarenal treatment was recommenced, on the second admission it was entirely without effect. P.M. examination revealed typical caseous suprarenal bodies without other complication except a few tubercles, quite recent, in the lungs.

Dr. Smith remarked that while at the commencement of the treatment some improvement was noted, he doubted whether it had really prolonged life. He did not reject the treatment as absolutely futile, but inclined to the view that if it is to be of service, it must be begun in the very early stages of the malady and be persistently employed, rather as a prophylactic against the advance of the lesion than as a curative for damage already done.

Subsequently to the patient's death it was stated that about two years previously to his fatal illness he had suffered from similar symptoms but had recovered in a few weeks. It would be interesting to know if this was merely alcoholic dyspepsia or whether it denoted the earliest deposit of tubercle in the glands; unfortunately the point can only be speculated upon.

THE PRESIDENT enquired if any symptoms of serious import had occurred after suprarenal extract had been taken.

DR. SMITH was not aware of any case in which serious symptoms had arisen.

MR. TUBBY mentioned one case in which it appeared that the patient had become worse while taking fresh suprarenal gland.

SPASMODIC CONTRACTION OF THE LEFT OCCIPITO-FRONTALIS.

Case shown by Dr. Arthur T. Davies.

DR. ARTHUR DAVIES brought forward a case of spasm of the left frontalis in a patient who had suffered from

mitral regurgitation. The patient was a woman aged 34, with a history of rheumatic fever, who suddenly in September, 1895, developed protusion of the left eyeball.

Suggestions as to the cause of the eye lesion were made by Dr. F. J. Smith, Sir Hugh Beevor, Mr. Rawes, Mr. Tubby, and the President.

Dr. Davies replied, and said that he inclined to the opinion that the ophthalmic appearance was due to spasm of the left orbitalis muscle.

BRONCHIECTASIS TREATED BY CREASOTE INHALATIONS.

Case shown by Dr. Arnold Chaplin.

Some twelve months ago I had the honour of reading a paper before the Fellows of this Society on the treatment of bronchiectasis by means of inhalation of commercial creasote. I then submitted the results of treatment by this method of six cases. I am now in a position to place before the Society the case of a man suffering from bronchiectasis, who has been treated for a month by the creasote inhalations.

The notes of the case are as follows :—

He is a strong, well-built man, aged 46, by occupation a seaman. There is nothing in his family history which throws any light on the case. Five years ago, while on the high seas, he had an attack of bronchitis, and he has been more or less subject to it ever since. Twelve months ago the bronchitis became worse, and at some time during that period the expectoration was noticed to be fœtid. In spite of this, however, he was able to pursue his vocation up till three months ago.

On admission to the City of London Chest Hospital the patient was found to have a very troublesome cough, coming on chiefly in the morning, and attended with the expulsion of large quantities of the most abominably offensive expectoration. The stench of this was so great that it pervaded the whole ward, and made it very unpleasant for those whose duty it was to be near him. He had lost weight to the extent of 15 lbs. in the last twelve months. Dyspnœa was severe

on exertion. His appetite was good, the temperature slightly raised, and the pulse normal. The fingers were clubbed. On examining the chest the left side was seen to move, but imperfectly. The note on percussion was impaired generally, and quite dull in the left axilla and at the base. The breathing was tubular, almost amphoric in the axilla and at the inferior angle of the scapula. From these signs and symptoms the diagnosis of bronchiectasis of the left lower lobe of the lung was tolerably certain.

He was placed under the creasote treatment, the exact nature of which is as follows. (Here followed a description of the creasote chamber and its arrangements.)

The results soon became manifest. After some days the following points of improvement were noticed :—

(1) Increase of expectoration.
(2) Feeling of freedom in breathing.
(3) Diminution of temperature.
(4) Decrease of fœtor.
(5) Gain of weight, 5 lbs.
(6) Decrease of moist sounds.

The treatment must be continued for several weeks, and the duration of each daily sitting should be about twenty minutes. When decided improvement is obtained, the treatment must be gradually discontinued, and not abruptly broken off.

Sir Hugh Beevor asked Dr. Chaplin for his experience of the intra-laryngeal injection of creasote in these cases.

Dr. Davies alluded to some specimens of Dr. Kingston Fyffe. He had injected rabbits with the sputa from the cavities of tubercular patients, before and after treatment by creasote. In the former case a variety of septicæmia occurred, but not in the latter. He also alluded to the freedom of those who creasoted railway sleepers from chest affections.

Dr. F. J. Smith thought that, if possible, surgical treatment afforded the best means of relief in addition to antiseptic treatment.

Mr. Tubby referred to Mr. Godlee's limitations of surgical interference.

EXTENSIVE AND PAINFUL GLANDULAR GROWTHS.

Case shown by Dr. Glover Lyon.

DR. GLOVER LYON brought before the Society a patient with extensive and painful glandular growths. The growths seemed to begin deeply in the left iliac fossa some years before. They appeared over the left sterno-mastoid 10 months ago, and now showed signs of penetrating into the chest from above. An enlarged vein passed from the left iliac fossa to the umbilicus. No special anæmia was present. Two glands in the axilla also were enlarged.

DR. F. J. SMITH thought that the enlargement of the glands was due to lymphadenoma.

The PRESIDENT thought that it was not a case of malignant disease of glands, but one of Hodgkin's disease.

DR. DAVIES enquired if bone marrow had been given.

SIR HUGH BEEVOR alluded to a case in which bone marrow had not been successful.

DR. LYON thought that the absence of symmetry was against the case being one of lymphadenoma, and there was no anæmia.

April 8th, 1896.—Ordinary Meeting.

TYPHLITIS.

Abstract of Paper read by Dr. Percy Warner.

DR. PERCY WARNER read a paper on a case of typhlitis. A gentleman, aged 35, was first taken ill on the evening of July 24th, 1895, with pain in the right renal region, running down in the direction of the ureter; he had noticed increased frequency of micturition of late. There was marked tenderness on pressure over the kidney in front and behind. There was vomiting with a slight rigor, and the temperature was 100° when first seen, and on the following day there was another rigor, with rise of temperature to 102.4, and exacerbation of pain. Bowels were always regular till attack began. Urine was normal. There was rigidity of

muscles of right side of abdomen and also dulness in the right iliac region. No well-defined tumour could be made out. He then began to improve and got well. Concurrently with the disappearance of muscular rigidity a well-defined tumour could be felt in the cæcal region, higher up than usual in typhlitis, which gradually decreased.

Patient was again taken ill on September 9th with the same symptoms, which subsided as before, but on the 19th there was great increase of pain, with considerable swelling above the crest of the ilium. Mr. Charters Symonds then saw the patient, but the swelling had to some extent subsided, also the tenderness, and we decided not to interfere. The symptoms continued for about a week, and the temperature fell to normal and remained so for a month, but the patient did not get on ; he began to perspire freely at night, and the pain came again in paroxysms, chiefly at night, and was situated most intensely on the crest of the ilium, at the junction of the posterior and middle thirds, running down over the gluteal region, as well as in the front iliac region. He was also unable to fully extend his thigh. His condition at this time showed a general malaise, progressive weakness, some loss of flesh and great paroxysmal pain, most frequently nocturnal, situated in the right iliac region and at the spot above mentioned. The temperature was from 100 to 102 at night, and from normal to 99 in the morning.

The rigidity of muscles made it impossible to define an iliac tumour, but there was certainly dulness. He was then anæsthetised and Mr. Charters Symonds operated. A fluctuating tumour was now felt in the iliac region, which was incised, and gave vent to a considerable quantity of foul pus. The finger was passed into the abscess cavity, which was of considerable size, and a large opening could be felt passing over the crest of the ilium, which was bare.

A counter opening in the flank was made, and a drainage tube inserted.

The patient made an uninterrupted recovery.

Remarks by Dr. Warner :—

(1) The frequency of micturition, which caused the

suggestion of a renal origin of malady, is not a very uncommon early symptom. In another case, treated as one of typhlitis, it was due to a large calculus in the right kidney. Dr. Warner also drew attention to the fact that other diseases often simulate typhlitis, as pelvic peritonitis, malignant disease, actinomycosis, omental tubercle with adherent omentum. The position of the appendix is so variable that this accounts for variation in the position of pain. Thus, it may pass upwards and inwards behind the cæcum and colon, across the sacrum, down into the pelvis or into one of the peritoneal pouches in the neighbourhood, or it may become adherent to the peritoneum lining the adjoining abdominal wall or viscera, and its length may vary from one to six or more inches. Thus the variation in the position of the pain is easily accounted for.

In the early stage it is frequently more or less central about the neighbourhood of the umbilicus, and is only particularly located in the right iliac region after the first or second day.

Sometimes it is general all over the abdomen, even though the peritonitis is only local.

It is not uncommon to find it most on the *left* side of the abdomen.

After suppuration has occurred, the position of pain depends on the position of the abscess, which is again dependent on the position and length of appendix, and the amount, character, and position of adhesions.

The position of the pain after suppuration in this case was at the junction of the posterior and middle thirds of the crest of the ilium, where the abscess had burrowed out of the iliac fossa into the cellular tissue of the gluteal region.

Carrington has pointed out that multiple abscesses of the liver are a not uncommon result of appendix disease.

The tenderness on pressure behind was remarkable. MacBurney drew attention to a spot situated $1\frac{1}{2}$ to 2 inches from the anterior-superior spine in a straight line drawn from the process to the umbilicus, at which he says deep pressure with one finger always elicits pain when the appendix

is diseased. This seems a fairly reliable symptom in the early stage.

In considering the question of treatment, the disease may be divided into three classes—

(1) Simple peri-typhlitis, where there is a local plastic peritonitis, generally ending in recovery, and having a great tendency to relapse.

(2) Peri-typhlitic abscess, the pus being localised by adhesions. There is generally, but not always, perforation of the appendix-wall in these cases.

(3) Peri-typhlitis, followed by general acute peritonitis, the result of acute perforation.

In the cases of peri-typhlitic abscess or localized suppuration following inflammation of appendix the obvious treatment is to open and drain. The difficulty consists in deciding when to operate, and resolves itself therefore into the diagnosis of the presence of pus, and no change in any one or two of the symptoms can determine this. It is on the clinical picture as a whole that we must rely. If the symptoms continue more than a week there is a suspicion of pus.

Again, the course of temperature is some guide ; if it rise again after fall to normal, suppuration is suggested. The severity or mildness of temperature is no indication of severity or mildness of attack.

The question of the presence of a tumour is often one of great difficulty to decide, but a great deal may be learnt from the behaviour of the ill-defined indurated swelling. Thus, if it comes on very rapidly at first, or if, after running the usual course, it subsides, and in a few days it again increases, or if it remains in a stationary condition for some time, pus may be suspected.

The general condition of patient must be also considered : tongue, pulse, skin, and physical and mental states.

In doubtful cases it would be advisable to examine under an anæsthetic, the value of which was seen in my own case.

There is another important side to the question of treatment, namely, surgical interference in the early stage.

Some American surgeons urge removal of the appendix in all cases of peri-typhlitis, as they assume that in all cases the disease begins in the appendix, and also that the organ is useless, and, being a degenerate organ, has less vitality and is therefore more prone to the attacks of antagonistic organisms. They say that, given a case of local peritonitis from disease of the appendix, it is practically impossible to determine from the symptoms in the early stage what course the disease is likely to run—*i.e.*, whether it will end in resolution, local suppuration, or general peritonitis; that the operation in the early stage is harmless and successful, and that the tendency to hernia of the abdominal wall can be easily counteracted; and although some say that we should never operate on an inflamed peritoneum, others say that this is a relic of the experience of the old septic surgery, and that if done antiseptically there is no increased risk.

But before deciding this question we must know the proportion of cases that relapse. Hawkins says one in four (this is probably too high); also that one in 38 suppurates, and that 13 in 100 of these have general peritonitis.

Then we must know also the percentage of deaths by the new method. Morris says it is less than 1 %.

Lastly, we must know the number of unnecessary operations done.

With regard to cases of relapsing typhlitis, there is a fairly general agreement that the operation should be done only in the quiescent period. Is this performed to avoid the risk of suppuration, or of doing away with recurrent attacks? This latter condition often renders the patient an invalid for a long time. Dr. Percy Warner quoted the case of a lady who, after five attacks in two years, refused operation, and has had no further relapse, and he compared these cases to the recurrent attacks of pelvic inflammation that some women have. He touched on the rheumatic origin of some cases, and as to

whether tubercle was ever found to be a cause of recurrent attacks.

Dr. F. J. Smith said he inclined more and more to mistrust the medical side of treatment, and he thought it best to call in a surgeon as soon as possible. He referred to a case he had lately seen of a patient aged 30, who whilst walking in his garden was suddenly seized with acute pain in the left groin with vomiting, retraction of testis, and frequent micturition. These symptoms he had considered as renal in origin, judging from the aspect of the case, but the frequent micturition pointed out by Dr. Percy Warner might lead him to modify his view, and that the case was probably one of peri-typhlitis. He then referred to the anatomical variations of the appendix, and pointed out that it is most commonly tucked along the posterior side of the ascending colon, which is the safest position. He also referred to a case where typical typhoid ulcers were found in the ilium, but where a Peyer's patch in the appendix had perforated and caused general peritonitis. Lastly he spoke of the close analogy between the tonsil and the appendix.

Mr. Charters Symonds referred to the remarkable tenderness which existed behind in Dr. Percy Warner's case. He also referred to another case on which he had operated, where pelvic cellulitis was found to be due to a perforating appendix. In another case, where a doubtful swelling was found in the right iliac fossa, and no operation was done, there was seen at the post mortem, pus about the cæcum. In another patient symptoms of peri-typhlitis were simulated by a suppurating kidney. In a patient seen with Dr. Bull, with a history of abscess in right iliac fossa, with distinct swelling, a large solid growth was found with a perforated appendix. Curiously the mother of the patient had a similar malignant swelling in the left iliac fossa. Epithelioma of the cæcum sometimes simulates peri-typhlitis and also actinomycosis. More chronic cases of peri-typhlitis resembled typhoid fever. Mr. Symonds thought it doubtful whether an operation could be too early performed : in one case he had operated in twenty-four hours, and in another in nineteen hours after the onset of symptoms. He showed a perforated appendix taken from a case operated on in the acute stage with an enormously dilated abdomen. He considered that if the peritoneum is healthy, one can deal with a localised suppuration even if the general cavity be opened.

Dr. J. H. Sequeira referred to three specimens of vermiform appendix in which were found fæcal concretions : one case had eight attacks in twenty-two months, and the disease was thought to be typhoid. In the second a great many adhesions were found, and in the third there was general peritonitis due to perforation. He referred to the two forms of the disease :

(1) Chronic with relapsing attacks.
(2) Acute suppurating form.

Mr. Hope Grant referred to the fact that salicylate of soda had done good in some cases.

Dr. Arthur Davies pointed out the relation of some cases of peri-typhlitis to rheumatism, and hence their successful treatment by salicylates, and said that this idea was based on the close analogy between the tonsils and appendix in structure.

The President said that the question to be decided in the treatment of the acute cases was whether the risk of the disease or the risk of operation was more formidable, and referred to diseases of the Fallopian tubes, causing recurrent peritonitis, where the question arose as to whether the Fallopian tubes should be removed. He accepted Mr. Charters Symonds's view of appendicitis causing peritonitis in the early stage of the attack. He thought the symptom of frequent micturition due to anatomical position, and he pointed out the usefulness of an anæsthetic in determining the diagnosis.

Dr. Percy Warner in his reply referred to Mr. Charters Symonds's case, where with no local physical signs the diagnosis had been made from general symptoms, which supported his own contention. He referred to the resemblance in chronic cases to typhoid fever, and related a case where multiple abscesses in the liver had been found. He also pointed out the importance of ascertaining what proportion of cases die after the first attack, and what is the proportion of the cases which recover. Lastly he was glad to find the opinion expressed that operation on an inflamed peritoneum was justifiable.

APRIL 22nd, 1896.—Ordinary Meeting.

NEUROPATHIC JOINT-DISEASE AND THE ARTHROPATHY ASSOCIATED WITH LOCOMOTOR ATAXY AND SYRINGOMYELIA.

Paper read by Mr. J. H. Targett.

Mr. Targett gave a demonstration on the morbid anatomy of neuropathic joint-disease, illustrating his remarks by numerous lantern slides prepared from actual specimens and from photographs of cases. The two diseases which were chiefly considered and compared were Charcot's joint-disease, or the arthropathy associated with locomotor ataxy, and that met with in syringomyelia.

Two varieties of Charcot's joint-disease were described: the one, a hypertrophic form, characterised by production of

new tissue about the articular ends of the affected bones; the other, or atrophic variety, presented marked destructive lesions. The changes in the various components of the articulation, as seen in a well-marked example of hypertrophic ataxic arthropathy, were then fully detailed. Alongside of destruction of articular cartilage, the subjacent bone, and the intra-articular ligaments (*e.g.*, the knee-joint) there was conspicuous evidence of new formation of bone, not only as osteophytes from the margins of the articular surfaces, or the synovial fringes lining the joint-capsule, but also as a thick periosteal deposit upon the lower end of the diaphysis of the femur. In this particular case described the disease began in a bed-ridden ataxic woman, and within six months the joint was completely disorganized. Hence the mechanical explanation of the arthropathy, and especially of the osteoplastic changes, was refuted. Some of the important differences between the morbid anatomy of Charcot's joint-disease and that of chronic rheumatoid arthritis or osteo-arthritis were then considered. In Charcot's disease the loss of bone was greater, and the resulting deformity more extreme; the exposed surfaces of bone showed little tendency to eburnation, or even osteosclerosis; osteoplastic periostitis of the adjacent diaphyses was not uncommon in the hypertrophic form, but did not occur in osteo-arthritis; lastly, one mode in which the destruction of the joint-surfaces was brought about in ataxia might be called "intra-articular fracture," or the separation of large fragments of bone rendered brittle by the disease—a condition not found in osteo-arthritis. Examples of such fractures in the elbow and knee joints were exhibited, the resulting deformity being very extreme. It was pointed out that the hypertrophic arthropathy was almost limited to the hinge-joints, such as the knee, ankle, and elbow; on the other hand, the atrophic variety affected the ball-and-socket joints, especially the hip and shoulder. No satisfactory explanation of this difference had been advanced, but it was suggested that as the knee had a much better blood-supply than the hip, possibly that might account for it.

On turning to atrophic arthropathy, several preparations from the shoulder and hip were exhibited. These showed marked destruction of the articular surfaces, but little or no evidence of new formation. In the case of the shoulder-joint, the head of the scapula and the root of the coracoid process were worn away, and a narrow crescentic surface articulated with the upper end of the diaphysis of the humerus, of which both the head and the two tuberosities had more or less disappeared. The exposed bony surfaces were not eburnated, nor had osteophytes formed around the joint ; hence the condition was quite unlike that of an osteo-arthritic shoulder.

Photographs of cases of syringomyelic arthropathy were then exhibited, several of which the author had had the opportunity of examining. From two of these cases the diseased joints had been obtained and carefully dissected. The appearances were fully illustrated by lantern slides. From the examination of the preparations, and from the records of similar cases, it was abundantly shown that the articular lesions of syringomyelia and locomotor ataxy were essentially the same. It was also possible to distinguish an atrophic from a hypertrophic arthropathy in syringomyelia, and the physiological distribution of the lesions was similar. One remarkable point was the tendency to ossification in tendons and ligamentous tissues near the affected joints. It had also been stated that a greater liability to suppuration of the joint existed in syringomyelia than in ataxy ; this was probably due to septic absorption through ulcers and other trophic lesions of the integuments.

In conclusion, the differential diagnosis of ataxic and syringomyelic arthropathy was discussed. Clinically, the cases differed in many important respects. In syringomyelia the cardinal symptoms were loss of sensibility to pain and temperature, muscular atrophy, and various trophic lesions of the skin. In 75 per cent. of the cases of arthropathy, due to syringomyelia, the large joints of the upper extremity were affected ; while in ataxia nearly 80 per cent. of the diseased joints belonged to the lower extremity. This was

explained by the difference in the situations of the spinal lesions in the two diseases, for in tabes the lumbar enlargement was usually affected, while in syringomyelia the changes in the grey matter of the cord were commonly found in the cervical and upper dorsal regions. Lastly, scoliosis was a very common symptom of syringomyelia, being present in nearly half the cases, but did not occur in locomotor ataxy. It was attributed to trophic lesions of the spinal joints and ligaments, but no careful dissection of the vertebral column in such cases had as yet been made.

DEFORMITY OF FEET AND TROPHIC CHANGES IN JOINTS AND BONES ASSOCIATED WITH (?) PERIPHERAL NEURITIS.

Specimens shown by Mr. F. S. Eve.

The specimens I am about to describe are, I believe, examples of distortion of the foot with trophic changes in the joints and bones from peripheral neuritis, or some nervous affection—not locomotor ataxy—associated with changes in the peripheral nerves.

Case 1.—The first specimen is from a patient I saw in the out-patient department of the London Hospital. Both feet presented all the appearances of extreme equino-varus, and there was ulceration on the outer sides and dorsum where they rested on the ground. The history of the case is as follows:—The patient was a man æt. 27, an umbrella maker. About ten years ago he noticed pain in the toes, followed by pain in the ankles, and soon after the deformity commenced. Gradually the patient got worse, and six years ago the outer sides of both feet got sore from pressure in walking. Up to the age of seventeen the patient was quite strong and both his feet were straight. There was loss of sensation in the lower thirds of both legs, with analgesia. The pupils reacted to light. No evidence of locomotor

ataxy existed. The muscles of the legs were wasted, the right calf measuring 11½ inches, the left 11 inches in circumference. The skin of the dorsum of the feet was dusky, glossy, and in parts the hair was long.

My colleague, Mr. McCarthy, under whom the patient was admitted, amputated both feet; he kindly allowed me to examine the specimens, and make use of the case. I found a remarkable condition of the joints (specimens shown).[1] In the ankle-joint, and the joints of the tarsus in both feet, the cartilages were almost entirely destroyed. In places the bone was exposed and slightly dense, but the cartilage had been replaced for the most part by fibrous tissue, which firmly united the opposing articular surfaces, rendering separation difficult. The articular surfaces were altered in adaptation to the altered relation of the bones, but there was no destruction. The muscles on the plantar surface of the feet were wasted, and so largely converted into fat that they could not be separated by dissection from the superabundant subcutaneous fat. The great toes were everted, and the little toes showed the claw or "Z-shaped" deformity.

This condition presents a great difference from that found in Charcot's disease, where the capsules are distended, the bones eroded—the tarsus feeling often like knuckle-bones in a bag. In this case the cartilages were destroyed, and their place taken by fibrous tissue, uniting the joints firmly. The anterior and posterior tibial nerves in both legs were enlarged, and the microscopic examination showed marked sclerosis. I have observed a similar condition to the above in the finger-joints in a case of long-standing injury to the median nerve.

Case 2.—Of the other case I can only show you a cast, and here we have also a curious deformity of the foot, associated with peripheral neuritis. The patient was a young man æt. 19, a barman. The changes in the foot were of recent origin. He had been in hospital three months

1 The specimen is preserved in the museum of the Royal College of Surgeons.

previously, with ulceration of the right foot. Now he came for ulceration in the left foot. There was no evidence of locomotor ataxy; the knee jerks were present, the pupils reacted to light and were equal, the plantar reflex was increased. The sensibility to heat and cold in the left foot was much diminished, although he could distinguish between heat and cold in it, but not in the right. There was marked anæsthesia, but he could distinguish a prick from a touch on the legs. Both feet showed much the same condition. In the first case described, there was extreme equino-varus; in this case there was spurious valgus. The arch was obliterated, the astragalus had fallen, the toes, especially the great, were everted, deformed, drawn up, or lost. Another remarkable feature was ulceration at the ends of several of the toes, with loss of the nails. There was an ulceration at the end of the second toe, and on the inner side of the great toe of the left foot. The phalanges of the great toe and of the second toe were found to be loose and necrosed on opening up the sinuses. Both toes were amputated.

This condition of the toes is very similar to that observed in the fingers in cases of anæsthetic leprosy, where we have, of course, enormous sclerosis of the nerves, the result of the leprous bacillus acting as an irritant to the nerves. The cause of the neuritis in the case related could not be discovered. He had not had syphilis. Being a barman, perhaps it was alcoholic, although no history of intemperance could be obtained. The late Dr. Ralfe kindly examined the case, but could throw no further light on this point, and confirmed the diagnosis of peripheral neuritis. The patient stated that a brother and an uncle had a similar affection of their feet.

Both these cases present one point in common with some cases of locomotor ataxy, namely, changes in peripheral nerves. In a measure they support the view that the trophic changes in joints, bones, etc., in locomotor ataxy, are largely due to changes in the peripheral nerves.

DISEASE OF LEFT ANKLE JOINT.

Case shown by Dr. Cotman.

DR. COTMAN showed the same case as last year (see Hunterian Society's Transactions, 1895-6, page 116).

MR. TARGETT had suggested that it was a case of Charcot's disease, when he first saw the patient. Thus it would be an example of arthropathy preceding the usual clinical evidence of locomotor ataxy. He now thought the swelling larger than when he last saw it and that it closely resembled some cases of Charcot's disease of the ankle joint.

A Fellow enquired if the patient had shown any ataxic symptoms.

DR. COTMAN said his pupils are equal, but do not re-act to light ; the patellar reflexes are normal.

DR. SMITH asked if the patient felt heat and cold as well as he did before.

DR. COTMAN replied that there was no deficiency nor exaggeration of sensibility.

MR. CHARTERS J. SYMONDS said : "My remarks will refer to the clinical aspects of the case, and particularly with reference to the foot which Mr. Targett showed. At the present time I have an important patient who has four perforating ulcers on his feet. I was called upon to operate, and found, on probing one of the ulcers under the little toe, that the joint was opened. It was clear that the base of the phalanx was smooth, and evidently had retained its cartilage, but that the head of the metatarsal bone was carious, so I cut it off. In a week the ulcer was closed, and in a fortnight it was healed, and remained so for months. In the case of the perforating ulcer on the opposite foot, at exactly the same point, I was not able to enter the joint, so the ulcer was curetted. The interesting point is that on both his little toes he had perforating ulcers with destruction of the joints and phalanges, and he had two little nodules there to represent his toes, so that spontaneous recovery may take place, even when the disease extends over two years. I had great hopes that the recovery would be permanent, because of the rapid healing after the operation, but recurrence has taken place. I attributed the failure on the other foot to the fact that the joint had not been entered. The case suggests that the primary disease may be in the joint rather than in the skin. This man has some of the early signs of locomotor ataxy. He has lightning pains and also a well-marked history of syphilis. Another case under my care had a perforating ulcer, and fourteen years ago I scraped this out, and the man reappeared with well-marked signs of locomotor ataxy and perforating ulcer on the opposite foot. I opened it up, and

found the head of the bone carious. I cut the head of the bone off, and the man was walking about in fourteen days. These facts point to a method by which we may relieve some of the patient's trouble. I had a man in my charge who had a little toe amputated, and subsequently the two centre toes, but finally we had to do Symes' operation for recurrence in the tarsus. Now he comes with disease in the tarsal joints of the opposite foot, but it has recovered largely under treatment. He has signs of locomotor ataxy at the present time. One thing strikes me specially with reference to the first patient. He is a very busy man, and is quite able to get about with four perforating ulcers on his feet. He walks and shoots. It is not always necessary to amputate; one may fairly well leave these patients alone for long periods. One man remained well fourteen years, and the other healed rapidly in the course of two or three weeks."

Dr. Fortescue Fox: "It would appear from the table indicating the distribution of the joint affections that in Charcot's disease the hip and knee are more particularly affected, and that this is not the case in syringo-myelia, where the joint most affected is the shoulder. In Charcot's disease may not the pressure of the body weight have something to do with the joint affection? With respect to the shoulder many cases of degenerative disease of the joint are met with in advanced life, and the right shoulder, elbow and thumb are especially prone to injury. This suggests a certain parallelism between syringo-myelia and traumatic or local arthritis. I do not know if Mr. Targett supposes that in Charcot's disease the bones are at all softened in the early stages, because the lower end of the femur, particularly in one of the photographs, is altered in such a way as to suggest that the bone has been pressed back when in a soft state, and thus produced the mushroom shape."

Dr. H. Horrocks: "A case came under my notice at the Manchester Royal Infirmary about five years ago. It is reported in the *Lancet* by Mr. Thos. Jones. A boy who had been previously operated upon for acquired talipes equino-varus in both feet, was re-admitted with evidence of some nervous lesion, under the late Dr. Ross. It was then found that he had pressure-symptoms referable to the sacral portion of the cauda equina, and from the existence of a small spina bifida Dr. Ross diagnosed a band pressing upon those nerves. A subsequent operation by Mr. Jones proved the truth of his diagnosis, and the removal of the band was followed by complete relief of the nervous symptoms."

Mr. Targett replied: "There is undoubtedly some change in the bones, as shown by their liability to spontaneous fracture, and this change consists in a great reduction of the amount of phosphates. The mushroom-shaped cup at the end of the femur is due to outgrowth of bone, a true osteophytic outgrowth, and not to any softening or alteration from pressure. Mr. Symonds' treatment by removal of the necrosed portions of bone exposed by perforating ulcers coincides with that recommended by French surgeons."

OCTOBER 14th, 1896.

DR. STEPHEN MACKENZIE delivered the second Hunterian Society's lecture entitled

"PURPURA: ITS VARIETIES AND TREATMENT."

THE PRESIDENT proposed a hearty vote of thanks to Dr. Stephen Mackenzie for the able and interesting paper he had read. The vote was carried with applause.

OCTOBER 28th, 1896—Clinical Evening.

ELEPHANTIASIS.

Case exhibited by Dr. Hingston Fox.

The patient is a man aged 62 years, who has never been out of England. Six years ago he vomited blood, a pint or more, on many occasions. His present ailment is of one year's duration. The swelling began in the calf of the right leg, and gradually extended upwards, reaching both groins and the genital organs, in about two or three months' time. Eight months ago he had an attack of erysipelas in the right calf. About two weeks previous to the first notice of symptoms, he sprained his right leg whilst steadying the foot of a ladder, the ladder having slipped.

Dyspnœa and increasing general weakness have come on during the last three months.

The right thigh and leg are considerably enlarged by solid œdema, scarcely pitting on pressure; the left leg is slightly enlarged; a roll of thickened skin, etc., containing large lymphatic glands, extends across both inguinal regions and pubes, from one ilium to the other; the scrotum and coverings of the penis are much enlarged, the former nearly to the size of a cocoa-nut, and the wall of the abdomen is also œdematous.

He has also an hypertrophied heart, thickened vessels, and urine of low specific gravity and containing a little albumen.

The point of interest in this case is the nature of the change which has produced elephantiasis. Dr. Manson states that the filaria is the chief cause of elephantiasis, but that the parasite, although it blocks the lymphatic vessels, is not generally to be found in the blood; also that the filaria has before now been found in patients who have never been out of England. This man's blood has been examined once (8.30 p.m., temperature under tongue 97·4°), by Dr. Fox, who only found some relative excess of white blood-cells. On the other hand the history of a sprain to the affected leg suggests local injury as the cause, inducing inflammatory action, perhaps erysipelatous at the outset, at any rate it was so later; and the lymphatics becoming blocked with inflammatory products, could no longer drain the affected area. The lymph spaces would thus become distended with partially coagulated lymph, producing the phenomena of solid œdema, and the thrombosis of the vessels once started has gradually extended until both limbs are affected. The more frequent occurrence of elephantiasis in the lower extremities is no doubt due to the favouring action of gravitation.

Mr. Openshaw thought the value of this case lay in the fact that it showed that all these cases were not due to filariae.

Dr. Bertrand Dawson, while agreeing with Dr. Fox that it was due to erysipelas, yet thought an explanation of the case might be found in the presence of immature ova, inasmuch as in such cases erysipelatoid attacks were not infrequent.

Dr. Glover Lyon advanced the opinion that the symptoms might be explained by venous thrombosis in the absence of filariae.

In reply Dr. Fox was inclined to agree with Dr. Bertrand Dawson as to the possible presence of immature filariae, and he could not accept Dr. Glover Lyon's explanation.

LYMPHADENOMA, ASSOCIATED WITH RHEUMATISM.

Case exhibited by Dr. Hingston Fox.

A woman, aged 37 years, married, no children, suffered from rheumatic fever at the age of twelve years, and has had varicose veins in the right leg ever since. Father died

at 42, asthmatic, insane ; mother living, has had severe "last-joint" arthritis in one finger. Catamenia regular. She has had enlarged lymphatic glands for nine months, dating from a badly inflamed left thumb, which suppurated ; the glands on the left side of the neck were enlarged at the time, and those on the right side of the neck followed. The axillary glands gradually became swollen, and the inguinal glands slightly so. She was given arsenic. At her second visit, October 12th, the tumours were all larger, and tender, the soft swollen glands being individually felt (not massed together as in strumous disease) ; each of the axillary masses considerably exceeded a walnut in size ; the glands above each elbow were also swollen. She seemed ill, temperature 100°, pulse 100. The case looked like one of acute lymphadenoma which would progress rapidly. I noticed however that her heart was of the "rheumatic habit," and as she had had rheumatic fever in childhood, gave her salicylates and alkalies. In a week the fever had subsided, and the masses had all become much reduced in size. They continued to shrink for two weeks, but during the last week have again rapidly enlarged and become tender. There is a suspicion that by mistake the salicylate has been discontinued. The spleen is not enlarged, and there is no anæmia.

I do not see that we can refuse to call this a case of lymphadenoma. There is progressive general enlargement of lymphatic glands, starting from a local suppurative lesion. These symptoms took on an acute form, possibly affected by the rheumatic poison ; and under salicylate of soda and alkalies rapidly subsided for the time. The question suggests itself, are gland inflammations in some cases rheumatic in their nature ? The intimate connection between joints and the lymphatics will be remembered, joints being in development modified lymphatic spaces.

Dr. Arthur Davies alluded to a case of lymphadenoma which had been treated with some success by red marrow.

Dr. F. J. Smith thought the case was probably one of lympho-sarcoma, not lymphadenoma, and asked if the blood had been examined.

Dr. Glover Lyon alluded to a similar case in which the glands had decreased after an acute febrile attack.

Mr. Tubby asked for further information as to the so-called "rheumatic habit" of heart.

Dr. Hingston Fox replied.

HYPERTROPHY OF RIGHT BREAST IN A MALE AGED 24.

Case shown by Dr. Arthur T. Davies.

Dr. Arthur Davies brought before the Society a case of hypertrophy of the right breast.

Thomas G., age 24, says his mother first noticed a swelling of the right breast 16 years ago: she took him to St. Bartholomew's Hospital 10 years ago. He does not think the breast has increased in size for the past 14 years. He has no pain in it. There is a doubtful history of a blow on the breast. No secretion can be squeezed out of the gland. No history of cancer in family.

The right breast is uniformly enlarged—about the size of a small Tangerine orange. The nipple and areola are well marked, and enlarged veins are seen coursing in the neighbourhood. There is a marked contrast between the two breasts.

Mr. Bryant in his work on Diseases of the Breast records nine cases which came under his observation, of which five were in women and four in men. Of the five women four were single and one married. Their ages were 17, 19, 21, 25 and 33 respectively. In three the left breast was involved only and in one (33) the right only.

Of the four male subjects, the ages were 18, 20, 25, 31, and of these the left breast was affected alone in three out of the four.

Marked enlargement of both breasts is seen in the males of the Queensland Aborigines, Pellew, Matlock and Rak Islands, and in the men of Ponapé in the Caroline Islands (*vide* Godeffroy Album).

Mr. Openshaw wished to know if the enlargement of the breast commenced at puberty and if there were any pain in it.

Dr. F. J. Smith doubted the existence of true hypertrophy in this case and was of opinion that the enlargement was due partly to periosteal thickening and partly fat.

Mr. Targett had examined several specimens of indurated male breasts which had been removed for pain. The ill-development of the acini and the presence of large amounts of fat and fibrous tissue were the chief features.

Dr. Hingston Fox agreed with Dr. Davies as to the nature of the case.

Dr. Davies in reply stated that there had been no pain and that the mother had noticed it first when the patient was 8 years old.

RENAL CALCULUS.

Case shown by Dr. Arthur T. Davies.

Henry H., age 23, admitted March 30, 1896, complaining of great pain in the left side, which began two years ago, and which he described as lancinating in character and working round the abdomen but not to the testis. The first attack lasted two hours. One year afterwards he experienced a similar attack lasting only a short time. A month ago he had another attack lasting some hours. He describes it as coming on quite suddenly. The pain is intense, radiating round the loin to the middle line of the abdomen and not descending down the thigh or to the testis. It leaves off as suddenly as it comes on. He had not noticed any alteration in colour of urine.

P.H.—Had an attack of left pleurisy with effusion in in 1887. Beer always increased the tendency to pain in side.

F.H.—His father passed a stone two years ago.

When admitted the patient was doubled up with pain which caused vomiting. There was less expansion of the chest on left side than on the right, and the note was impaired somewhat. No pain was felt over left kidney on deep palpation.

Urine—1018—cloud of albumen. Under the microscope, blood and granular cast with oxalate of lime crystals and pus cells were seen in great number.

As the symptoms continued I asked my surgical colleague, Mr. Stephen Paget, to explore the left kidney with the view of finding a calculus. This he did on March 16th. The

kidney was exposed by a suitable incision and was found to be uniform in shape with no bulging. A hare-lip needle was passed into it and on the first puncture grated against some hard substance. An incision was made into the kidney following the course of the needle with a tenotome and a finger introduced, which immediately came upon a calculus which was found lying in the pelvis of the kidney and was removed by a scoop. The calculus was composed of oxalate of lime and uric acid.

The patient made a perfect recovery.

Remarks.—No pain on deep palpation, a point strongly emphasised by Sir Henry Thompson: also the fact that the majority of cases of nephralgia are not calculous in origin.

No pain radiated down to testicle or to inner side of thigh.

There seems to be no doubt that the attacks of pain were due to the calculus irritating the renal pelvis and not to the passage of the stone into the ureter, which was formerly thought to be a proof of such fact.

Similar attacks of pain are seen in cases of hepatic colic where the gall-stones never leave the gall-bladder.

Dr. Glover Lyon thought that the X-rays would have revealed the presence of the stone.

Mr. Openshaw made remarks on the distribution of pain, viz., its absence in the testis and down the thigh.

Mr. Tubby observed that it had been found when a stone was localised in the substance of the kidney, the testicular pain was most severe.

FIBROID DISEASE OF THE RIGHT LUNG.

Case shown by Dr. Bertrand Dawson.

Dr. Bertrand Dawson showed a patient with fibrosis of the right lung with creaking, displacement of the heart and increased tactile vocal fremitus. This patient had been treated for consumption for some years, but Dr. Dawson believed it to be fibrosis and bronchiectasis.

Dr. F. J. Smith concurred with Dr. Dawson.

Dr. Hingston Fox was anxious to know if hypertrophy of the right side of the heart were present.

Dr. Dawson, in reply, said that hypertrophy existed.

COMPOUND COMMINUTED FRACTURE OF THE LOWER END OF THE LEFT HUMERUS.

Case shown by Mr. T. H. Openshaw.

Mr. Openshaw introduced a patient who 12 years previously had sustained a compound comminuted fracture of the lower end of the left humerus, which now presented a deficiency in bone for $1\frac{1}{2}$ inches at the site of fracture, yet the patient was able to carry on his daily occupation and move the elbow with perfect control.

HYPERTROPHY OF THE ALVEOLAR PROCESSES OF UPPER AND LOWER JAWS.

Case shown by Mr. T. H. Openshaw.

Mr. Openshaw also showed a case of hypertrophy of the alveolar processes of upper and lower jaw, which he believed to be idiopathic.

Dr. Hingston Fox drew attention to the patient's age, which was 25. He wondered if the alveolar processes had continued to grow while the growth in the other part of the bones had ceased.

INFANTILE HEMIPLEGIA AND TALIPES EQUINO-VARUS.

Case shown by Mr. T. H. Openshaw.

Mr. Openshaw also showed a case of infantile hemiplegia with talipes equino-varus on the left side and contraction of the left fore-arm and hand. In this case there existed a deep depression of the right parietal bone, which was present at birth.

NOVEMBER 11th, 1896.—Ordinary Meeting.

ETIOLOGY OF ACUTE RHEUMATISM.

Abstract of Paper read by Dr. McClymont.

DR. MCCLYMONT remarked that Dr. Humphreys had read a most interesting paper relating cases of an apparent infection. During the last year Dr. McClymont had devoted some time to the study of the etiology of acute rheumatism. Dr. Farre as Registrar General included acute rheumatism among the zymotic diseases; but at his death it was relegated to the class of constitutional disorders. The factors may be intrinsic or personal, and extrinsic, or factors relating firstly to conditions of environment, and secondly to an active infective agent as a final cause.

The personal factors dealt with age, sex, heredity, constitution, and temperament, previous disease, injury, chill, fatigue, occupation, diet and race. The conditions of environment related to the geography and geology of the disease, climate, season, weather, air, soil, temperature, ground-water, and storm centres.

Evidence of an infective agent is surmised from a study of epidemiology, from the clinical history and analogies of the diseases of the specific rheumatic series, from the result of treatment, and it receives support from bacteriology.

With reference to constitution, temperament, and heredity, Dr. McClymont said that notwithstanding Dr. Pye-Smith's excellent statements in the Hunterian Lectures of 1892, against the too easy presumption of a rheumatic diathesis, he thought we saw a type of patient in whom we could prophesy a tendency to acute rheumatism, or assume a past history of the disease. And we have seen whole families who have suffered from some specific rheumatic affection; nephrolithiasis had been frequently noted by the writer in the families and relatives of rheumatic patients.

With reference to the chemical theories, lactic acid is the chemical agent chiefly regarded as being associated with acute rheumatism, and Latham's ingenious and admirable

theory will well account for its possible presence, its continued formation, and the sequel of a protracted illness. But so far as the writer could gather its presence is very hypothetical. But even if lactic or uric acid be present in the disease it does not destroy the infective theory. The organisms which have been described as associated with acute rheumatism grow rapidly in the presence of an acid, in fact they set up lactic acid fermentation. The writer then alluded to the question of previous diseases. It was pointed out that with reference to anæmia it is interesting to note that acute rheumatism is a common sequence of anæmia but not of chlorosis. While, according to Dr. Hutchinson, the alkalinity of the blood is decreased in the former case. As to the part taken by chills in the production of acute rheumatism, it was suggested that by depressing the system or by causing the formation of an auto-toxin such as sarco-lactic acid it is conceivable that chill lays the patient open to an inroad of some pathogenic organism. Rapid variations of temperature, more especially when accompanied with over-fatigue or acting on a person crippled by some previous disease such as those mentioned, especially favours the onset of acute rheumatism. The geography and geology of the disease have been specially worked out by Dr. Newsholme, and without attempting to follow him throughout his lengthy statistics and observations, the writer stated that Dr. Newsholme proved conclusively that acute rheumatism is an urban disease. And statistics bearing upon this point are that in Bombay the case-ratio of acute rheumatism is 66·7 per 1,000 as against 3·4 of other diseases. Dr. Newsholme has also pointed out that when the mean soil-temperature is raised rheumatic fever is much more prevalent, and his studies in connection with the rainfall and ground-water, and the occurrence of rheumatism are most important. Dr. Newsholme concludes that heavy rainfall is usually coincident with a diminution of acute rheumatism, and increased production of the disease appears in such dry years as 1881, 1887, and 1893.

The active infective agent in acute rheumatism. Evidence from epidemiology. There are times when the total number of cases of acute rheumatism is so increased that the disease can only be spoken of as epidemic, and such epidemics may be protracted or explosive. That they vary in type as regards severity and organs specially affected as well as in case frequency is a strong argument for an infective theory.

Evidence of infection.—In one house in a period of two and a half years I have attended five cases of acute rheumatism, two with endo- and pericarditis, four cases of diphtheria, one of pleurisy, and six of follicular tonsillitis. In another house in one year, two of acute rheumatism, three of tonsillitis, and three of diphtheria. Two of these patients with tonsillitis had a scarlatiniform rash, and one erythema marginatum. In a third house in eighteen months there were three cases of acute rheumatism, one of sub-acute, and one of chorea; this last patient throughout was always showing some phase of rheumatic condition as sub-cutaneous nodules, erythema, œdema, pericarditis and arthritis. In a fourth house in three months, four cases of tonsillitis, one of acute rheumatism and pericarditis, one of sub-acute rheumatism, and one of goitre and endocarditis occurred. In a fifth house in eighteen months, a boys' school, two cases of diphtheria, three of acute rheumatism, one of chorea and endocarditis, and about ten of follicular tonsillitis, and these are all the illnesses except measles that have been in the house. In twelve of these cases it was the first attack of acute rheumatism, in the second and fourth case the sequence of illness was so remarkable that the writer could not help thinking that there was evidence of a contagious virus being present. In the second case the mother had follicular tonsillitis and scarlatiniform rash with erythema marginatum; the baby sleeping with her developed tonsillitis and a rash; six months later the baby had tonsillitis again; an aunt in the house a week later developed acute rheumatism and endocarditis; and the grandmother sleeping with the aunt had acute rheumatism. In case four the sequence was as remarkable. The mother had follicular tonsillitis, and

the daughter followed with it in a week ; a month later the mother had a relapse, fourteen days afterwards the daughter contracted acute rheumatism, endo- and pericarditis. A sister attending to her now followed with goitre and endocarditis, then sub-acute or at least slight acute rheumatism, and lastly finished up with tonsillitis. It was next argued that the pathological appearances found in acute rheumatism and the clinical symptoms supported the theory that the disease was due to an infective agent, seeing that the course of the disease was precisely that of an infectious disorder such as erysipelas or pyæmia.

Bacteriology. Dr. Mantle of Halifax had obtained most constant results in examining for bacteria, and these results he reported at the British Medical Association in 1886. The writer attempted to obtain cultures from the blood during a typical case of acute rheumatism. He begged to thank Dr. Fred. J. Smith for the material in two cases under his care at the London Hospital. In five of the cases the broth-tubes remained frequently clear and sterile after inoculation. In the sixth case they turned turbid throughout, but after repeated examination no definite growth in the culture was discovered. The seventh case was one of subcutaneous nodules and active endocarditis. The peptone-broth on the fifteenth day showed a copious growth resembling the acetous fungus. Microscopically it consisted of micro-cocci. These were single or in zooglæic masses, or most frequently taking the form of diplo-cocci. The organism stained well with aniline dyes and by Gram's method. Sub-cultures were quickly obtained in acid beef-broth. In the eighth case, which was one of acute rheumatism and pericarditis, the writer obtained an exactly similar growth. Microscopically these organisms are much the same as Dr. Mantle's, but he describes his as a short bacillus, and also sometimes as a coccus, while in Dr. McClymont's cases it was a diplo-coccus which was most frequent. The culture tubes were kept at blood-temperature, but even then these organisms grew slowly as compared with most others.

In conclusion, the writer suggested that the cases of acute rheumatism occurred principally in the wet season of dry years; that the rise of ground- or soil-water drives out a specific poison; that acute rheumatism is associated with other telluric and drain diseases, such as diphtheria and some forms of tonsillitis. In this way may be accounted for groups of cases, epidemic prevalencies, and its spread.

The evidence of contagion is incomplete, but it seems likely, especially when tonsillitis is present.

Dr. F. J. Smith, while thanking the reader of the paper, expressed his disappointment at the absence of more convincing bacteriological observations and proofs. He quoted Dr. Sutton's opinion that in acute rheumatism the patient's vaso-motor system was not able to co-ordinate with the change of external temperature with sufficient rapidity.

Dr. Hingston Fox asked the writer of the paper for a definition of acute rheumatism. He thought that the so-called acute rheumatism was really a clinical group of symptoms due to a variety of causes.

Dr. Charlewood Turner thought that in so far as acute rheumatism had "infective" pathological characters, it was probably due to micro-organisms.

The President agreed with Dr. McClymont as to the "great probability of a microbic origin." He thought that the chief point in the question was that of the micro-organisms falling upon suitable soil. He hazarded the opinion that in acute rheumatism a poison was produced which affected the central nerve-system. He could not agree with Dr. McClymont as to drainage of a defective character being a possible cause.

Dr. Arthur Davies alluded to the blister treatment carried out by the late Dr. Herbert Davies.

Dr. McClymont then replied.

NOVEMBER 25th, 1896. Ordinary Meeting.

THE TREATMENT OF CHRONIC BRONCHITIS.

Paper read by Dr. Arthur Davies.

In the remarks I am about to make on the treatment of chronic bronchitis, I cannot claim to bring forward any novel form of procedure. The means employed are indeed numerous, and the therapeutic armamentarium is well

furnished with weapons for the combating of the disease, and yet, as Whitla truly remarks in his "Dictionary of Treatment," unfortunately we do not know the class of case in which some methods fail and others succeed until we try, and occasionally the physician will find himself combining several in one prescription—"*mitrailleuse* like." Still, in spite of this statement, a somewhat prolonged experience has convinced me that certain methods do stand out alone in their influence for good, which have apparently fallen out of use, or if used are not so widely known as they should be.

Some years ago I came across a paper by Dr. S. Ringer and Dr. Murrell, on "The value of the Ipecacuanha Spray in Winter Cough and Bronchitic Asthma." These results were so strikingly successful that I determined to test this method of treatment. They stated that the merits of their system consisted in the facts that it, without any internal administration of the drugs usually employed, tends to rapidly relieve the dyspnœa, to loosen the phlegm and expectoration, and above all to cut short the case more quickly than the ordinary routine methods usually employed. Their manner of employment consists in spraying, by means of an ordinary hand-ball spray apparatus or the steam atomiser of Siegle or Richardson, the ipecacuanha wine, either alone or diluted in a proportion of 1-3 of water. The patient is directed to inhale as deeply as possible, at the same time closing his nose with his fingers. The amount sprayed at a single sitting consists of one to four drachms—100 sqeezes of the hand ball is equivalent to one drachm of the spray used. The patient must also be directed not to swallow any of the spray which may accumulate in the mouth, but to spit it out. I have now used this plan of treatment for some time, and am satisfied from my own experience that the claims of its authors are not exaggerated. I need not narrate all the cases I have thus treated—suffice it to mention one or two which may be taken as types of others. The first case was that of a lady, who suffered from bronchitic asthma, the attacks of dyspnœa being worse at night—all the usual

remedies were employed without much avail, until ipecac. wine spray was used. This gave rapid relief to the dyspnœa, and in a short time the patient was well.

William T., aged 39, has suffered from winter cough for six years; complains of dyspnœa, worse at night, which prevents him from lying down, difficulty of expectoration, and has lost flesh.

On examination the chest is found to be barrel-shaped, impaired in movements, tympanitic note all over, with rhonchi of varying intensity and character. During the first month of admission into the hospital the ordinary ammonia and pot. iod. mixture was tried. As there was only slight improvement, the ipecac. wine (1 in 3) spray was ordered to be administered once a day with the most satisfactory result. The dyspnœa rapidly improved, the cough became less, while the expectoration was freer, and in six weeks the patient was discharged as being well.

Isabella W., aged 35, has suffered from winter cough for 15 years. She complained of much dyspnœa, distressing cough, and much expectoration; and she had great difficulty in getting to and from the hospital. Her aspect was livid, and on examination her chest presented in a marked degree the signs of chronic bronchitis and emphysema. As she refused to come into the hospital, I instructed her to come up and have her throat sprayed with ipecac. wine. After the first inhalation she said that she was able to get home nicely, and also that her breathing had become easier and the oppressive tightness of chest relieved. I have stated that the advantages of the treatment are that it tends at once to markedly relieve the dyspnœa, and so promote sleep, and to shorten the duration of the case. Each patient spontaneously remarked that their breathing was easier, and the oppressive tightness across the chest relieved, and that the deeper the inhaled spray seemed to penetrate into the lungs the more relief they obtained. What are the disadvantages? In hospital practice it is of course an easy matter to carry out the treatment systematically, but it is not so in private practice. The amount of the spray must be carefully

regulated, as at first it is sometimes not well borne, and tends to induce vomiting, and sometimes severe paroxysmal dyspnœa. The strength of the spray requires careful adjustment. In some cases no benefit is obtained, owing to the awkwardness of the patient in arching his tongue. Lastly, in true asthma, the ipecacuanha tends to aggravate the disease.

I have also tried a spray of a 1 p.c. solution of pot. iodidi. This also will relieve the dyspnœa, and is especially useful in cases of asthma, and in persons of a gouty tendency. A patient of mine, suffering from the dyspnœa of chronic bronchitis, described the sensation after inhaling the iod. of pot. to that of taking in a draught of fresh air into his chest. I may mention that iodide of potassium is the basis of a remedy advertised under the name of spirone, which is found to consist of this salt dissolved in acetone and glycerine.

The spray of tartar emetic, antimonial wine, and lobelia are also said to be of use, but these I have not used. Dr. Murrell recommends jaborandi, but it has the disadvantage of staining—thus he tells of an old gentleman who came to him with a snow white beard, and, after the inhalation, went away with a green one.

It will be seen from the above remarks that the class of case in which the method advocated is suitable is that where there is a history of repeated yearly attacks of bronchitis, with symptoms of distressing dyspnœa, orthopnœa, frequent violent paroxysmal cough, with consequent sleeplessness and difficulty of expectoration. This class of case is one which so often resists the ordinary modes of treatment usually employed. I have been struck with the marked relief to the dyspnœa, which is invariably the first symptom to be benefited, as I can testify from personal experience.

Another remedy, which I have found of the utmost value in the treatment of chronic bronchitis, is trinitrine. In cases where there is great dyspnœa, high tension, and signs of struggling at the heart, it affords marked benefit. To take my most recent instance.

John D., aged 55, a carman. Admitted October 30th, 1896, complaining of severe cough with shortness of breath, attacks of dyspnœa especially at night, thick muco-purulent sputum, has had a winter cough for 15 years, and hamoptysis one year ago. On admission, the dyspnœa was considerable, especially on exertion.

Very limited respiratory movements of the chest-walls, heart-dulness diminished, tympanitic note, rhonchi heard all over the chest, slight œdema of the legs and orthopnœa were all present. I ordered him the trinitrine tabloids every four hours; he obtained most rapid relief to the dyspnœa, which in about ten days practically ceased to give him the slightest trouble.

In another patient (whom I was asked to see in consultation), aged 60, the subject of winter cough for many years, and who had very distressing dyspnœa with lividity, and in whose chest there was found marked rhonchus and sibilus, and scattered râles, the trinitrine administered every three hours afforded very marked relief. In this case there was also high arterial tension. It has seemed to me to be especially of use just in those cases where bleeding is indicated in order to relieve the right heart, but whereas bleeding gives relief directly by removing a portion of the burden of the right heart, trinitrine affords assistance to it indirectly by its vaso-dilator effects, thus promoting the suction action of the left heart; in this way it may be regarded as a *vis a fronte*. Probably the new vaso-dilator, erythrol-tetranitrate, would be equally, if not more beneficial, as its effects are more prolonged. I may add that I order the trinitrine to be given every two, three, or four hours, according to the severity of the dyspnœa. It must be given frequently to be of use.

In cases where there is only a moderate degree of dyspnœa tar is very valuable. It can be given in various forms, but none surpass, in my opinion, the Syrup-Picis prepared according to the U.S. Pharmacopœia. I am in the habit of using it largely amongst my out-patients with good results, giving it frequently as a linctus. Tar is highly recom-

mended by Whitla in the form of tar water in doses varying from a teaspoonful to half a pint. Another advantage of tar is that it is very cheap, an important point in hospital economy. Sometimes the addition of 4-6 minims of a 2 per cent. sol. of apomorphine is useful.

Terebene has been largely advocated in the treatment of chronic bronchitis. I find a very useful way of giving it as an inhalant, if the bowl of a pipe is filled with cotton wool and a few drops be poured on it. The patient can very conveniently inhale it whilst at work. Several of my out-patients have derived much relief to their dyspnœa in this way. Lastly, in the treatment of fœtid bronchitis and bronchiectasis, the method of causing the patient to inhale the fumes of crude commercial creasote in a small chamber is advocated by Dr. Arnold Chaplin. I had under my care last year a very striking case in point. A man was admitted with constant troublesome cough and the most fœtid, foul expectoration, with loss of appetite, and a high temperature at night. The creasote chamber afforded very marked relief, both as regards the amount and fœtor of expectoration, and reduction of temperature.

In conclusion, I would say that I do not, of course, claim that each of the methods will invariably answer, but speaking from the experience gained by many years connection with a chest hospital, where, of course one has the opportunity of trying every possible line of treatment, I can say that these methods are of the greatest value, and seem to answer where others fail. In this disease, perhaps more than in others, the Hippocratic aphorism is well illustrated—*ὁ βιος βραχυς, ἡ δι τεχνη μακρη.*

Dr. F. J. Smith asked Dr. Davies for information on the class of cases known as bronchitic asthma. The speaker also enquired if Dr. Davies was satisfied as to the value of ipecacuanha when swallowed as an expectorant.

Dr. Glover Lyon was surprised to find that Dr. Davies had not alluded to the value of ammonium carbonate and of cod-liver oil. The use of oxygen in cases of bronchitic emphysema and advanced dyspnœa was alluded to.

The President remarked that the point of Dr. Davies's paper lay in the fact that the dyspnœa of bronchitis was relieved by inhalations of ipecacuanha wine.

Dr. Hingston Fox alluded to remedies other than those which Dr. Davies mentioned, especially the external application of turpentine.

Dr. Cotman also spoke of the value of ammonium carbonate and he was accustomed to give it in the form of the ammoniated tincture of quinine.

Dr. Rawes spoke of the value of limiting the ingestion of fluid in preventing the advent of dyspnœa in chronic bronchitis.

Dr. Davies in reply stated that he had found ipecacuanha given in the ordinary way, i.e. by the mouth, of little or no avail.

THE VALUE OF A CORONER'S INQUEST.

Paper read by Dr. J. S. E. Cotman.

Mr. President and Fellows,—The subject to which I desire to direct your attention for a few minutes this evening is one which, though not of scientific interest, nor yet one tending to the advancement of professional knowledge, is yet one the consideration of which is fully justified to such an assembly as this.

There is probably no Fellow present to-night but has some interesting reminiscence connected with his attendance at an inquest.

I have entitled my paper the *value* of a coroner's inquest because I desire to elicit the opinions of those present as to that value.

Coroners have great discretionary powers, and they are bound, under certain circumstances, to hold an inquest; but I take it that the true purpose of a coroner's inquest is to ascertain the cause of death in those cases in which a medical man is unable to certify. Do you consider that as at present conducted it serves the purpose for which it is held? and if not, why not?

Personal experience leads me to disbelieve in their efficiency.

First, I affirm that inquests are often held unnecessarily.

Second, that in some cases where such an enquiry is desirable such an enquiry is not held.

Third, that in many cases where an inquest is held the verdict is valueless, owing to the absence of a *post mortem* examination.

I will illustrate my first point.

A few months ago a lad of 16 years or so was playing with a fourpenny-halfpenny toy pistol, into which he had put a cartridge, and he could not get it to go off. While opening the breach it went off and wounded him in the palm of his hand. He went to business as usual the next three or four days. I was called to see him on the fifth day, and found him suffering from tetanus, of which he died two days after. The cause of death was so evident that it never occurred to me that an inquest was necessary, and I gave the certificate, which was refused by the registrar. An inquest was held. The time of the jury was wasted, the feelings of the parents harrowed, the funeral delayed, with no possible advantage accruing to anybody.

Now let me illustrate my second point, viz., that in some cases where an enquiry is desirable such enquiry is not held.

Some 16 or 17 years ago I was doing *locum tenens* work, and therefore a stranger in the neighbourhood. I was called to see a man, a groom, living over some stables. I found him in intense pain, so much so that I was unable to make a satisfactory examination. The man who fetched me informed me that it was not a first attack. I gave him an opiate, and early the next morning word was sent me that he was dead. I refused a certificate. The coroner's officer called upon me and said the coroner wished to see me about it. I went to him, and put the few facts before him. He said that he did not consider an inquest necessary, and advised me to give a certificate. I told him that I did not know the cause of death. "Maybe," he replied, "that's your fault; you saw him before he died." I was younger then than I am now, and I yielded; but I have always had it on my mind that that man might have died of poison.

We now come to my third and most important point, viz., that in many cases where an inquest is held, the verdict is valueless, because of the absence of a *post mortem* examination.

I will illustrate this by giving you an account of two cases which have occurred to me during this year.

A man in the employ of one of the larger railway companies, and in that capacity coming for years under my occasional care, came to me complaining of pains in his chest and vomiting after food. Careful examination revealed nothing. I put him on a suitable diet, and treated him for dyspepsia. He came again on the second day to get some more medicine, and left a message with my dispenser that he was better. On his way home he called at his station; while there he was taken with sudden pain, and one of his mates took him home in a van. He was given some brandy, which he vomited, and some hot port wine, which he also vomited. The pain continued, and he died within an hour of getting home in a state of collapse.

Just before his death he was seen by a gentleman acting for a qualified man who has an open surgery in the immediate neighbourhood.

Upon being applied to for a certificate I declined to give one, unless I could first satisfy myself by *post mortem* examination that a perforating gastric ulcer was, as I suspected, the cause of death. This was refused, and I heard no more of the case until the second day after the death; upon calling at the station to make enquiry, I was informed that an inquest had been held—that the cause of death had been attributed to heart disease, and a verdict of death from natural causes returned.

Of which did the man die? Certainly not of heart disease. No one in the room, after hearing the symptoms, would commit the folly of supposing this. Had any medical man been present at the inquest he must have known this.

My point, however, is this. Did the man even die of natural causes?

My third point is, in my opinion, so important that I must endeavour to emphasize it with another illustration.

About a month ago I was called one morning hurriedly to a house close to me to see a woman alleged by the

messenger to be already dead. I went and found that she was dead. She had not been seen by a medical man for 16 days. The following day at one o'clock a summons was left at my house commanding me to appear at 5.45 the same day. I attended at considerable inconvenience, as I did not get the summons till after 3 o'clock.

The husband gave evidence that his wife, the deceased, had been delivered of a child a month before, that she was not a strong woman, and had suffered from dropsy (?) during her pregnancy. That he left her in bed looking pretty well, but upon going up an hour later he found her dead.

I was next called, and asked by the Coroner to tell the jury what I considered to be the cause of death. I replied that I had no opportunity of forming an opinion.

You examined the body ? Yes, part of the surface.

Any marks of violence ? No.

Any contortion of feature ? No.

Any signs of a struggle ? No.

Then you would say that death was probably due to heart disease ? No, I would not.

What, then, do you think might have been the cause of death ? It might have been one of many things.

Will you name one of them ? It might have been due to natural causes and it might not.

Upon this a juryman spoke up, and said that 'twas evident to the jury that a *post mortem* was necessary.

I was then asked by the Coroner why I had not asked for a *post mortem*, and I replied that no opportunity had been given me, I had only received the summons to attend two hours or so before the time of inquest.

Well, gentlemen, he said, I am in your hands, and if you desire it I must adjourn the inquest for the purpose. (Note the implied trouble to the jury.)

A brother of the deceased then got into the box, and said the family were quite satisfied and did not want any further step taken. That his sister had been ill and so forth. All

his evidence was second or third hand, for he had not seen his sister for weeks before her death.

The Coroner, then addressing the jury, said : Now, gentlemen, you have heard what the brother of the deceased has said. I do not desire to influence you in any way, but do you now, in view of the later evidence, consider an adjournment necessary? And the jury didn't ; and I maintain that as a consequence of this a doubt will always rest in my mind as to how this woman met with her death.

Coroners, even though they be medical men, seem to be under the impression that medical men are always after the fees, and they, I believe, pride themselves upon the number of *post mortem* fees they can save the ratepayers.

I am convinced that there is not a man in this room that does not consider a guinea to be a ridiculously inadequate fee for a *post mortem*, and that it is an entirely false assumption that a medical witness desires to spend his time so unprofitably save in furthering the interests of justice. The miserable places in which examinations have to be conducted, the cold wet slabs, the inadequate appliances, the disagreeable hands, the fee to the mortuary keeper, the subsequent attendance at the court to give evidence, this, for an extra guinea, with a cold thrown in, surely is not "a boon and a blessing" to any man.

In my opinion, sir, a medical man attending an inquest to give evidence should be the adviser of the coroner, especially if he be not a medical man ; but even if he be so, it should not be possible for a coroner to conclude an inquest without a *post mortem* examination when the expert witness is of opinion that it is required to clear up a case.

Dr. Smith enquired if any practical enquiry was likely to be the outcome of this paper. The direction of activity which this Society might assume should be that of a petition praying for an enquiry into the matter.

The President alluded to the Scotch practice of the Procurator Fiscal acting under the advice of a medical man. He thought this was an improvement on the English system.

Dr. Glover Lyon thought that the question of getting up a petition should be referred to the Council.

Dr. J. H. Sequeira spoke of the existence in some cases of murder and suicide of simultaneous enquiries by the coroner's court and the magistrates' court.

Mr. John Adams spoke in favour of a coroner's enquiry in all cases of death from violence. He thought that medical men with a legal qualification should be appointed as coroners.

Dr. Cotman in reply quite agreed with the suggestion of Dr. Smith as to a petition, but he was not sure as to whom the petition should be presented. He maintained the object of his paper to be the improvement of the relations of medical man and coroner. The medical man should be treated as an expert witness and not as an ordinary witness.

DECEMBER 9th, 1896. Clinical Evening.

ACUTE RHEUMATISM ASSOCIATED WITH FIBROUS NODULES.

Case shown by Dr. W. Campbell McDonnell.

W. McG., aged 30, had served in the Guards. His father and mother were not rheumatic, nor any of his brothers. The patient had acute rheumatism in 1888, when he was aged 22, and was laid up for one month, and was one month convalescing. In the summer of 1893 he had pain in the hands and over his body, lasting about six months. In the spring of 1896 a fibrous swelling on the left buttock was noticed. At first it was not painful, but gave rise to tenderness on pressure. The swelling on the right buttock has been present about six months, and the third swelling is now situated just about the left ischial tuberosity. In the first week of November he complained of general pains in the joints. The largest nodule is now seen to have a diameter of one inch. There are no cardiac signs, and on that account alone the case is interesting, since most physicians report cardiac lesions as usually being present with these fibrous nodules. The differential diagnosis lay between

rheumatic nodules, gummata and tubercular growth, but the absence in the history of points other than rheumatic tends largely to favour the diagnosis of rheumatism, and there seems nothing else to suggest as a reason to outweigh the *prima facie* adoption of this view of the case.

Dr. F. J. Smith thought that from the symmetrical position of the masses they might be bursæ.

Mr. Openshaw thought that they were fibromata, and the masses correspond in feel with that of rheumatic nodules, especially that over the ulna.

Mr. A. H. Tubby concurred with Mr. Openshaw.

Dr. E. W. Goodall alluded to a case of scarlatina succeeded by erythematous patches. In the position of these patches fibrous nodules developed, and the patient had an attack of rheumatic fever. The patient did not make a satisfactory recovery, and finally left the Fever Hospital much wasted and anæmic.

Dr. McDonnell replied, and thanked the Fellows for the interest they had taken in the case.

TUMOUR OF THE CEREBELLUM.

Case shown by Dr. Henry Head.

Benjamin Barker, aged 22, a milk-carrier by occupation, was quite well until the morning of October 3rd, 1896, and he was doing his work as usual. At 11 a.m. he suddenly became giddy, sat down on the pavement, and vomited four times. He came to the out-patient department, and was admitted the same afternoon. There had been no discharge from the ear at any time, and there had been no venereal disease. On admission the speech was not affected. There had previously been no fits, and only one attack similar to the preceding. Since 11 a.m. he vomited six times. It was noted that he could not stand without help, and when supported, if the support is slightly removed, he makes a wild, inco-ordinate plunge to the right, exactly like a man thrown off his legs by the lurch of a ship. If allowed to fall, he falls entirely to the right, except that just before he touches the ground he throws himself on to his back. A hand placed in the right axilla is quite enough to prevent his falling.

On the other hand, a person walking on his left side has great difficulty in holding him up. The grasp of the right hand is distinctly weaker than that of the left. The most marked feature, however, is not so much the weakness as the extreme paresis of the right hand. He is able to approximate the thumb to the tips of the fingers with great difficulty only. In the same way when told to bring the tip of one finger in contact with the next, he fails at first. He cannot touch his nose with the right index finger as accurately as with the left. Closing the eyes seems to make little, if any, difference to this inco-ordination. There is not the same obvious inco-ordination of the movements of the right leg. To movements to order he responds fairly well, but his gait shows inco-ordination, otherwise difficult to obtain. There was no tremor at first, and no signs of wasting. There was no profound loss of the sense of position. The knee-jerks were equal, there was no ankle clonus, and the plantar reflexes were equal. No ocular paralyses were present, and no ptosis. There was slight nystagmus in both horizontal directions. The pupils reacted well to light and accommodation. The movements of the face were equal, and the tongue was put out straight. In the right eye there was marked hyper-metropia, and some swelling of the disc, with filling in of the cup.[1] In the left eye there was marked hyper-metropia, but the optic disc was normal. With reference to the supposed optic neuritis of the right eye, that cleared up. Mr. Eve, on examining the patient, could find no trace of neuritis. A watch was heard three inches away from the left ear, and the membranes were normal. The smell was good, the taste was poor on both sides of the tongue, the sphincters acted normally. He very much improved during his stay in the hospital, left on November 8th, and went to a convalescent home, with slight inco-ordination in the right arm only. He had had no attacks in the hospital, but on the second day after his arrival at the home, November 11th, he felt giddy and fell down five

1 Messrs. Waren Tay and Eve both thought the appearances of the disc due to the high degree of hyper-metropia.

stairs. He vomited, and was then able to eat a hearty breakfast. November 15th, he vomited again in the morning. November 20th, he was walking along the road and became giddy as before, and before he could cry out fell into the ditch on his right. He walked home about a mile. November 24th he had another attack. On December 3rd, 1896, he was re-admitted. The grasp of the right hand is distinctly less than that of the left. A marked tremor has made its appearance in the right arm and hand, and there is very marked inco-ordination in the right hand. He still sways slightly to the right. There was also noted an apparent wasting of the right first dorsal inter osseous. There was also distinct nystagmus to the left, but no ocular paralysis, and the movements of the face were good.[1]

The PRESIDENT remarked that the case was a very interesting one, and that the following points were awaiting solution, viz., the situation and nature of the growth and the possibility of its removal.

DR. F. J. SMITH agreed with Dr. Head's diagnosis.

MR. OPENSHAW alluded to a case of hæmorrhage in the cerebellum, in which coma came on rapidly, and death followed in nine hours.

DR. HEAD in reply, said that he had seen a case in which the whole of one lobe of the cerebellum had been removed, and the patient always fell to the right, as this patient did.

PERFORATION OF THE HARD PALATE.

Case shown by Dr. J. H. Sequeira.

The patient, a girl aged eight years, has been under my care at the North-Eastern Hospital for Children since March, 1896.

The mother gives the following history :—She has had seven children, of whom two only survive. The first died at the age of three years from scarlet fever and diphtheria. The second child was the patient. At the next birth there were triplets, who only lived a few days. The next child died in convulsions when seven months old. The youngest child, now about six months old, has enjoyed good health. There was one miscarriage, which occurred about a year

1 This patient has subsequently recovered.

before the patient was born. There is no direct evidence of syphilis.

Owing to the mother's ill-health, the patient was not suckled, and suffered severely from improper feeding when six weeks old. There is no history of skin affections. The child has always been delicate, but was especially so after having had whooping cough. Three years ago she had "inflammation of the left lung," and in the winter of 1894 had a severe attack of influenza.

The present illness dates from October, 1895. The child became pale, and was troubled with shortness of breath and cough.

In February, 1896, she was ill for three weeks with "rheumatism." When I first saw her, a month later, she was anæmic and thin. The breath was foul, and there was a discharge from the nose. I examined the mouth, but detected no sign of perforation. As the palate is unusually high I may have failed to see a small opening. The physical signs in the chest were interesting. The heart's impulse was one inch outside the nipple line, and there was a dull area at the base of the left lung. The heart sounds were normal. Its altered position was evidently due to contraction of the left lung, following the pneumonia in 1893.

A fortnight later the patient vomited or coughed up some foul smelling material like pus; and when I saw her there was a large irregular perforation in the hard palate. The edges of the mucous membrane around it were sloughing. Deglutition was painful, and food passed into the nasal cavity. A week later both tibiæ were swollen and tender. From that time she has been taking iodide of potassium and small doses of the liquor hydrargyri perchloridi, in a bitter infusion, and also extract of malt.

The perforation at first increased in a forward direction, but is gradually closing. There has been no trouble with deglutition for some time now, and her general health has improved remarkably.

It is of interest to note that the teeth are in no way characteristic of congenital syphilis. Mr. Hutchinson has

drawn attention to this feature in cases of perforation of the hard palate. The fact of the patient having had periostitis of the tibiæ, and joint affections, together with her improvement under specific treatment, leaves no doubt as to the nature of the lesion in this case, and the mother's history confirms it.

The points of interest which have led me to show the case are the extreme rapidity of the necrotic process in the hard palate, and the long process of healing, although the patient's general condition has so remarkably improved.

Mr. Tubby deprecated any surgical interference with the idea of closing the perforation.

Dr. Hingston Fox quoted Mr. Hutchinson's opinion as to the value of iodide of potassium in preference to mercury in specific tertiary ulcerations.

Dr. Sequeira replied.

DEFORMITY OF THE HAND FROM EPIPHYSIAL INJURY.

Case shown by Dr. J. H. Sequeira.

The patient, a healthy girl aged 9 years, presents a remarkable shortening of the ring finger of the left hand. In fact, this finger is but slightly longer than the little finger. The shortening is in the metacarpal bone, and amounts to three-eighths of an inch. It is well seen when the finger is strongly flexed into the palm, the absence of the prominent head of the fourth metacarpal being marked by a hollow in the line of the knuckles.

Three years ago the patient injured that hand, and there seems little doubt that the epiphysis of this metacarpal bone, which is at the distal extremity, was injured, and in consequence there has been failure of growth. Mr. Jonathan Hutchinson, Jun., and Mr. Tubby have lately directed attention to the results of this class of injury. Its occurrence in this position is an unusual condition.

Mr. Openshaw doubted if all the shortening were due to delayed growth at the epiphysial line, but thought part of it arose from the displacement forwards of the metacarpal head into the palm of the hand.

Mr. Tubby agreed with Dr. Sequeira's diagnosis.

MYXŒDEMA.

Case shown by Dr. Butler Harris.

Dr. Butler Harris exhibited a case of myxœdema with the usual signs, which had been subjected to thyroid treatment with very satisfactory results.

Dr. F. J. Smith spoke of a case in which the symptoms of myxœdema and exophthalmic goitre were combined. The patient was not benefited by thyroid treatment.

Dr. Butler Harris, in replying, said that the patient had been regular, but had lost a stone in weight.

January 13th, 1897. Pathological Evening.

SOLID OVARIAN TUMOUR, REMOVED TEN DAYS AFTER CONFINEMENT.

Specimen shown by Mr. T. Horrocks Openshaw.

The patient was admitted to the London Hospital October 10th, 1893, for an abdominal tumour. She had been confined ten days previously, and noticed the tumour first after her confinement. On admission there was a large globular tumour filling the centre of the abdomen, extending one inch above the umbilicus. The right flank was resonant and the left dull, the abdomen was distended, and a wave of fluctuation could be felt over it. The tumour was hard and the hand could be passed behind it on the right side. On examining the uterus it was found to be movable. The cervix was soft and patulous, the sound passed $3\frac{1}{2}$ inches. *Per vaginam* the cervix uteri was high up and no part of the tumour could be reached. Dr. Herman reports as follows:—"The limitation of the tumour makes me think it be ovarian, but the solidity and wasting and the œdema incline one to the suspicion that it may be malignant." On October 23rd, it was noticed that the lump was very

movable. The fluctuation was very distinct. It felt very like a fœtus floating in amniotic fluid. The fluctuation was more distinct than Dr. Herman had ever known with a pregnant uterus of this size. It was possible it might be an extra-uterine gestation or a second fœtus, but the thinness of the bag which contained the fluid was against this. An operation was duly performed. A large quantity of ascitic fluid escaped from the abdomen. The uterus was found to be healthy and the tumour proved to be ovarian with a twisted pedicle and adherent by soft adhesions in many places to the intestines. On section the tumour was found to be solid with softened red areas of necrosis in it. After the operation the patient did well and convalescence was only interrupted by the re-development of ascites and pleuritic effusion.

Dr. Herman spoke on the question of recurrence of sarcomatous tumours of the ovary and said that such was by no means certain.

Mr. Targett alluded to the fact that fibro-myoma of the uterus was sometimes associated with ascites, in the same manner as solid tumours of the ovary.

Dr. F. J. Smith alluded to two cases of sarcoma of the omentum, one with much ascites which simulated extra-uterine pregnancy, and the second a solid growth with but little ascites.

PARTIAL LOSS OF SHAFT OF TIBIA AFTER ACUTE PERIOSTITIS.

Specimen shown by Mr. T. H. Openshaw.

Mr. Openshaw brought before the Society the leg and foot of a boy aged 15, who at the age of 7 had had acute periostitis of the shaft of the tibia. In the specimen, part of the shaft of the tibia had not been reproduced, while the fibula had continued to grow. The superior tibio-fibular articulation was very loose and, owing to the absence of part of the shaft of the tibia, he could twist the foot through an arc of 260 degrees.

Mr. Tubby in speaking to Mr. Openshaw's point on the propriety of waiting before removing the dead bone thought that it was better to

remove the sequestrum early and to maintain the cavity of the periosteum by stuffing it with gauze.

Mr. Targett said that in some cases of congenital abscess of the tibia the deformity was like that seen in Mr. Openshaw's patient.

Mr. Openshaw, in reply, said he preferred to wait before removing the sequestrum.

MALIGNANT DISEASE OF THE BODY OF THE UTERUS.

Specimens shown by Mr. Targett.

Mr. Targett exhibited two specimens of malignant disease of the body of the uterus; one of a villous character, and the other a columnar-celled carcinoma. In neither was the cervix uteri affected.

Dr. Herman remarked that it was unusual for an uterus with malignant growth of the body to be of such size as the specimen Mr. Targett had described. Dr. Herman thought that in cancer of the body of the uterus the microscope by itself was not always trustworthy from a diagnostic point of view.

SECONDARY CARCINOMA OF THE SPLEEN.

Specimen shown by Dr. J. H. Sequeira.

The specimen was obtained from the body of woman aged 50. There was advanced carcinoma of the body of the uterus, extending to the Fallopian tubes, with extensive deposits in the peritoneum and glands. The liver also contained some small nodules. The organ was obtained from the dissecting room, the body having been injected with formic aldehyde solution. The shape and consistence of the soft abdominal organs were thus well preserved. The splenic tumour is situated at the periphery of the organ, and on section measures three-quarters of an inch by half an inch. Microscopically the growth consists of masses of glandular cells of irregular shape, containing large nuclei. The comparative rarity of secondary deposits of cancer in the spleen was commented upon.

Dr. Herman remarked that cases of cancer of the body of the uterus do not frequently (ten per cent.) give rise to secondary growths in distant organs.

Dr. F. J. Smith remarked upon the comparative infrequency of secondary splenic growths.

DESTRUCTION OF LIGAMENTUM TERES IN THE COURSE OF OSTEO-ARTHRITIS.

Specimen shown by Dr. J. H. Sequeira.

The specimen was obtained from the body of a man aged 56. The head of the right femur shows the characteristic eburnation and extensive "lipping." The point of interest is the complete destruction of the *ligamentum teres*. The opposite hip and both shoulder joints are affected. The symptoms were of several years' duration.

At the pathological meeting of the Society in December, 1895, Dr. Sequeira showed a specimen of a shoulder-joint in which the intra-articular part of the long head of the biceps had been similarly destroyed by rheumatoid arthritis.

Dr. Smith asked if the ligamentum teres were ever congenitally absent, and Mr. Openshaw remarked on its absence in congenital dislocation of the hip.

Dr. Sequeira replied.

LARGE WHITE KIDNEYS.

Specimens shown by Dr. F. J. Smith.

Dr. Fred. J. Smith showed these specimens which were taken from the body of a boy æt. 15; his history was as follows:—Father alive and well, mother æt. 30, said to have some kidney trouble, but its precise nature was not known. The boy himself had smallpox as a small child, and three years ago had an undescended testis removed (it is unfortunate that the urine was not then tested, but as the wound healed by first intention, the fact is of some slight weight by itself in favour of sound kidneys), otherwise he knew of no

illness whatever till about three weeks or a month ago, when he first felt unwell at night school—faint and "seedy," with some nausea. The next morning the face was puffy, and he had slight pain across the back. In the next week he was sick occasionally, and his urine was "very dark for 24 hours and red for a week." His condition, diagnosed as acute nephritis, showed no improvement for three weeks, then he was sent into hospital under Dr. Smith's care. On admission he was very pale, somewhat puffy in the face, and with very slight œdema of ankles and shins, but nothing like general anasarca. The alimentary system was nearly normal, except that he vomited about once a day. The pulse tension was a little high, but otherwise the vascular system was natural. The respiratory system was healthy. There were no headache, convulsions, nor tendency to somnolence, nor coma. He was in hospital from December 3rd, 1896, till he died, on December 21st, and from the first never showed the slightest sign of improvement. Death was due to uræmia, of which definite evidence first showed itself about a week before death, when he began to feel sleepy ; a comatose condition gradually developed, and he died profoundly unconscious. During the 18 days his urine was tested 9 times ; the quantity passed in any 24 hours varied from 6 ounces on the last day to 54 at the end of his first week's stay. For the whole 18 days it averaged just under $21\frac{1}{2}$ ounces for each 24 hours ; its specific gravity was never under 1016, varying irregularly from that to 1020 ; the quantity of albumen was on the 9 times of testing solid, $\frac{5}{6}$, $\frac{4}{5}$, $\frac{3}{5}$, $\frac{4}{5}$, $\frac{5}{6}$, $\frac{5}{6}$, $\frac{5}{6}$, and the deposit showed a few red blood corpuscles and numerous epithelial casts. On autopsy the kidneys were large and white, with the cortical substance apparently very fatty, in fact a very typical example of the large white kidney as described in text-books.

Remarks by Dr. Smith :—

I have brought this specimen forward to-night as one of interest for two reasons—firstly, because I do not think that such typical specimens of large white kidney are very common ; and secondly, and I must say chiefly, that I might

express an opinion on the clinical history of the case and elicit the opinion of other Fellows in return. My opinion, expressed definitely in the form of a proposition, is this :— Large white kidney as a clinical entity is an acute disease of the organ, and not, as text-books usually infer, a chronic affection with a history of years of ill-health and definite urinary pathological changes. I must give my colleague, Dr. Henry Head, the credit of having started me into formulating my opinion, but the above case and that of two others, which he quoted to me, have convinced me of the soundness of it. The condition has to be separated as a clinical picture from what we may term consecutive nephritis—occurring, that is, as a sequel to acute nephritis—which presents on post mortem, kidneys which are mottled, muddled, and dirty-looking, either somewhat larger or, more probably, smaller than usual, the capsule not stripping so readily, and slightly thicker than normal. The symptoms of a large white kidney are sufficiently accurately given in all text-books of medicine. It is the acuteness and short duration of the illness which I believe have been overlooked or misstated. If my contention is correct its great importance will be at once obvious in matters of life assurance, where the death of the insured within 18 months of his being passed as a first-class life might throw doubt on the *bona fides* or carefulness of the medical officer, especially if the post mortem examination reveals a condition usually accepted as very chronic.

Dr. Arthur Davies spoke on the points of cyclical albuminuria and life assurance.

Dr. Herman was much interested in the discussion as it was closely connected with puerperal eclampsia.

Dr. Smith replied, and thanked the Fellows for the interest taken in the matter.

ANEURISM OF DESCENDING AORTA IN A BOY AGED NINE YEARS.

Specimen shown by Dr. F. J. Smith.

Dr. Smith presented the lungs and trachea from a boy aged 9, who was brought into the London Hospital dyspnœic

and moribund. Tracheotomy was performed unsuccessfully. At the post mortem an aneurism of the descending aorta was found.

Unfortunately the hour was late, and there was no opportunity of discussing this unique specimen.

January 27th, 1897.

SPRAINS AND THEIR TREATMENT.

Abstract of Paper read by Mr. A. H. Tubby.

(Printed in full in '*The Practitioner*' for April, 1897.)

A sprain is a momentary disturbance of the normal relation which exists between the opposing bone surfaces, but varying in degree. In some cases the injury is slight; in other cases it may be such as to rupture the ligaments; while in others again it is so severe as, in those cases described by Mr. Callender, to tear off with the ligament a small portion of the articular surface. The latter are known as "sprain-fracture."

Before describing, however, what actually takes place in a sprain, it may be well to enumerate the structures which form a joint. We have, of course, the bony surfaces, more or less adapted to one another; the synovial membrane, with its vessels; the sub-synovial tissue, full of connective-tissue cells, lymphatics, and blood-vessels; the ligaments, composed mainly of fibrous tissue, and in themselves inextensile, and, what is somewhat to the point, as long as they remain unstretched they are, so to speak, insensitive: but directly they are subjected to undue stretching or pressure they become acutely sensitive. Outside the joint we find tendons lying in vascular sheaths, muscles which are truly elements of the joint, and, in some cases, bursæ, into all of which, and into the tendon sheath, effusion either of lymph or of blood may take place. The synovial cavity of the joint is in reality a large lymph sac covered by stomata, from which the lymph is carried away into the lymphatics around the joint.

The *symptoms* of a sprain are sufficiently well marked. In severe cases the patient faints from the pain produced. The pain at the time of accident is referable to several causes; stretching of the ligaments in one part and giving of the ligaments in another part; sudden effusion into the joint, and a general stretching and tearing of the parts around the joint. The pain becomes less severe shortly after the accident, and for a time there is a period of quiescence, lasting three or four hours, and then the pain increases in intensity, the second advent of the pain being due to tension arising from extravasation into the joint cavity, and also into the parts around the joint which have suffered. In a short time swelling appears, due partly to effused blood and effused lymph in and around the joint. The swelling is especially noticeable at those parts of the capsule which are not supported by ligaments and by muscles. With the increase of pain and swelling the movements of the joint become limited, and the patient is unable to walk. After a time, usually three or four days, subcutaneous extravasations of blood can be made out, and such extravasations are always most marked where the damage to the ligaments and the peri-articular tissue is greatest, and give an indication as to one detail of treatment.

Such, then, are the main features of a sprain. The essential point to bear in mind is the existence of two stages as indicated by two attacks of pain: the first being the stage of injury, associated with stretching and tearing of the parts and effusion of blood; and the second occurring after an interval of two to three hours of more or less quiescence, being the stage of tension and continued effusion. Of course fractures and separations of the epiphyses should be carefully excluded. In doubtful cases, after the lapse of some days, if we have reason to question our diagnosis in the case of a sprain, the diagnosis can be cleared up by observing the tender spots[1] about the joint. These tender spots existing after a sprain

1 Such a tender spot is found in the knee, just to the inner side of and below the patella; in the ankle, at the front of the external malleolus.

generally mark the situation of roughened, inflamed synovial fringes, or sometimes of spots where there has been extravasation of blood into the joint capsule. In severe and old-standing cases these tender spots may be indicative of the position of bands of adhesion. It is important to remember the existence of these spots and the causes of them, since there arises very considerable difficulty, after a sprain, in getting rid of pain there. Patients often express themselves dissatisfied that, while they are able to move about, their locomotion is accompanied by considerable pain at the spots which have been mentioned.

Now, with reference to the question of *treatment*, the means at our command are the following. The application of cold and of heat, properly applied pressure, immobilisation by splints or plaster-of-Paris, friction, and the use of the constant current, are all valuable in their place, but the true treatment of sprains consists in the appreciation of the right time to apply them. The application of cold, either by ice or by cold water, or by evaporating lotions, has of late years fallen into considerable discredit, but I think undeservedly. And the discredit to which it has come is due not to the agent itself, but to a non-intelligent method of applying it.

Let us go back for a moment to what happens at the time of a sprain. As the result of the injury various vessels are ruptured, and there is an instantaneous pouring out of a certain amount of blood and of lymph. This pouring out goes on for three or four hours after the injury. It is during those three or four hours that cold is so effective, and it acts in the following direction :—It is as a local constringent of the vessels, limiting their size and lessening the effusion. Now, if a less effusion than otherwise would have been the case, is poured into a joint, the time of healing is lessened, the probable amount of stiffness afterwards is also decreased, and the patient is able to get about much sooner. There are also two other means which may be employed at this stage to check the amount of the effusion. These are the application of pressure, and placing the joint in such a position that its potential cavity is lessened. For instance,

the knee should be placed in extension and not flexion, the ankle at a right angle, and not in full extension nor in full flexion, and so on. In applying bandages it is of no use merely to put on the ordinary bandage, since by it pressure is made on the prominences of the bones at the joint. But pressure must be so applied that it is brought to bear evenly on all parts of the capsule which can be got at. For example, in the case of the ankle-joint, a bandage around the ankle presses mainly on the internal and external malleoli and on the tendo Achillis behind. But, now, if three or four layers of cotton wool be placed on the joint and the bandage then firmly applied, the cotton wool, so to speak, sinks into the various hollows of the bones and effectually compresses the distended capsule.

If the second stage of the symptoms of sprain has come on, and the pain, which passed off somewhat after the injury, has now become more severe, the application of cold is not of much value, since by this time the tissues have become distended with blood and with lymph, and if the parts have been kept at rest effusion will have ceased now to be poured out. The most prominent and troublesome symptom is that of pain. Nothing succeeds now so well in diminishing the pain as the frequent application of hot water, or, better still, of hot vinegar and salt—an empirical but very successful remedy. It seems that hot applications not only diminish the pain, but also exercise a permanent effect upon the duration and upon the amount of the swelling; and it is in this way: when the vessels which have been injured have recovered their tone, the application of hot water promotes absorption, so that the effused blood and lymph are rapidly taken back into the blood-vessels and the lymph-channels. During this time the joint should be kept at rest, and it is advisable also to maintain pressure on it by cotton wool, since well-directed pressure also promotes absorption.

As to this all-important question of rest. How long should it be carried out? As a rule, most joints are rested too long, and one may say that, taking an average, three or four days after the swelling has subsided, movement of the

joint should be commenced. Now the movement of the joint is also an important point to be attended to. It has already been stated that we can ascertain by the distribution of the extravasated blood, which part of the joint has been most injured. To take, for example, injury of the external lateral ligament of the ankle. No one would be so unwise as to invert that ankle, but would flex and extend and carefully evert it, so that while moving the joint he would be in no way interfering with those parts which have been so recently injured. It should not be forgotten that constitutional conditions influence the question of sprains very considerably. For instance, one must be careful in the treatment of a tuberculous patient, and see that such a patient rests much longer than an ordinary one.

In some cases the amount of swelling is very considerable, and it is not merely sufficient to put on hot applications and to place the joint at rest, but something more must be done. The best method is properly applied directed friction. The object of friction is to empty the lymphatics of a certain amount of coagulated lymph which blocks them ; and in rubbing the part it is always advisable to begin to rub that part of the swelling which is most distant from the joint, thus emptying the lymphatics at that part first, and then those parts which are nearer the joint, and so promote circulation of lymph from the most congested to the least congested parts. This is a valuable "wrinkle," and one which has always been attended with considerable success. Together with the rubbing, frequent ablutions of the part with hot water, or the application of hot vinegar and salt, should be adhered to at this stage.

If, after ten days' treatment of this kind, the thickening about the joint has not disappeared, and there still remain tender spots on moving the articulation and on making pressure, counter-irritation by iodine, or, better still, by blisters, is indicated. As a rule, one may say that in fourteen to seventeen days, with treatment as above indicated, a severe sprain will cease to give rise to trouble and inconvenience, and the patient will be able to walk about with comfort.

Sometimes, however, it happens that on the patient attempting to use the joint, acute pain sets in again. Such pain is due to subacute congestion of the joint, and the only treatment for it is absolute and complete rest. This is most effectual if the joint is placed in plaster-of-Paris, and in some instances four to six weeks is not too long to keep a joint entirely at rest. After a joint has been at rest so long, movements will necessarily be awkward, stiff, and not infrequently painful. Generally speaking, such pain does not arise from adhesions within the joint, but is really due to the condition of the muscles. They are at this stage somewhat atrophied, and their tendons are more or less glued in their sheaths. The best means of overcoming the difficulty is friction with stimulating applications, such as lin. chlorof., and I frequently use a liniment composed of lin. opii, lin. bellad., together with the preceding. In addition to this, the use of the faradic current is of value, more especially if there be muscular wasting and stiffness without much pain. If there is much pain or tenderness present the constant current answers better, as it seems to not only improve the nutrition of the muscles but to remove the pain.

If, however, there should be considerable stiffness without pain coming on after the prolonged rest, and not removed by friction and the use of the faradic current, forcible movements of the joint under anæsthetics should be carried out.

Dr. F. J. Smith thought that in some points the treatment of sprain was entirely different from fracture, although both were due to rupture, one of the soft parts and the other of the bones. He alluded to a point mentioned first he believed by Mr. Mansell Moullin, viz., if the patient be away from help, the value of field or garden mould around the joint as a means of compression and support.

Sir Hugh Beevor asked as to the treatment of sprains by massage within two days after the injury

Dr. Fortescue Fox spoke of cases of chronic sprain complicated by teno-synovitis. He was of opinion that in the case of the knee-joint the tender spot was just above and to the inner side of the insertion of the ligamentum patellæ. Dr. Fox was averse to treating most cases of sprain by rest, especially after middle life.

Dr. Ettles alluded to the use of opium liniment and doubted if any absorption of opium could take place.

Dr. Herman referred to cases of chronic weakness of the muscles around a joint, *e.g.*, in atonic flatfoot, some cases of scoliosis, knock-knee, etc. He asked as to the effect of rest in producing atrophy of muscles.

Dr. F. J. Woods observed that he had in many cases removed the pain after sprains by "suggestion" and manipulation.

Mr. Tubby replied, and thanked the Fellows for the interest they had taken in a paper on so simple a subject.

PELVIC CELLULITIS.

Abstract of Paper read by Mr. T. H. Openshaw.

Mr. T. H. Openshaw read a paper on "Pelvic Cellulitis." He quoted a case in which an abscess had been opened above the middle of Poupart's ligament, and after four months the patient was discharged from the hospital with a sinus, ultimately dying of exhaustion. He also spoke of a second case which was discharged with a sinus; and of a third which had only healed after some months. The speaker deprecated early surgical interference unless it were absolutely necessary. The points of urgency being implication of the peritoneum or internal viscus, and suddenly wide tracking of pus. He contended that some cases got well spontaneously, and that the majority of the remainder did better if allowed to burst by themselves. He quoted five cases in support of his contention.

Dr. Herman was disposed to leave matters much to nature. About half the cases suppurated, and nine-tenths of these opened just above and to the outer side of Poupart's ligament.

THE ANNUAL GENERAL MEETING,

February 10th, 1897.

The President, G. E. Herman, Esq., in the Chair.

Drs. J. S. E. Cotman and J. H. Sequeira were appointed Scrutineers of the Ballot.

Report of the Council :—The Council's report for the past year was read and adopted.

Balance Sheet :—The Balance Sheet was passed after having been duly audited by Messrs. F. Gordon Brown and Hope Grant. The thanks of the Society were accorded to the Auditors.

The Report of the Hon. Librarian was read.

It was proposed and seconded that a congratulatory message be sent to Lord Lister from the Society on his elevation to the peerage. Carried unanimously.

Alterations in Rules 1, 62, and 64 (*vide* p. 125) were duly sanctioned by the Council.

Mr. Symonds proposed and Dr. F. J. Smith seconded a cordial vote of thanks to Dr. Herman, the President of the Society, for his valuable services during the past year. Carried unanimously.

Dr. Herman replied.

Dr. Oliver proposed a vote of thanks to the Vice-Presidents, Treasurer, and Librarian during the past year, which was carried unanimously, and Dr. Davies replied.

Dr. Fortescue Fox proposed a vote of thanks to the Auditors, Secretaries, and Council during the past year. Carried unanimously.

Dr. Hingston Fox was proposed for Vice-President in the place of Dr. Arthur Davies, who had accepted the office of Hon. Sec.

The Scrutineers examined the balloting papers, and declared the Officers elected as follows :—

LIST OF OFFICERS, 1897-8.

PRESIDENT.

G. Ernest Herman, M.D.

VICE-PRESIDENTS.

T. H. Openshaw, M.S.
Hingston Fox, M.D.
S. H. Appleford, M.D.
Fred. J. Smith, M.D.

TREASURER.

F. Charlewood Turner, M.D.

TRUSTEES.

H. I. Fotherby, M.D.
F. M. Corner.

LIBRARIAN.

T. H. Arnold Chaplin, M.D.

ORATOR.

Peter Horrocks, M.D.

SECRETARIES.

A. H. Tubby, M.S.
Arthur T. Davies, M.D.

COUNCIL.

Sir Hugh Beevor, Bart., M.D.
J. S. E. Cotman.
L. A. Dunn, M.B., M.S.
Fortescue Fox, M.D.
Hope Grant, F.R.C.S.E.
John W. Oliver, M.D.
William Rawes, M.D.
Henry J. Sequeira.
St. Clair B. Shadwell, M.D.
L. E. Shaw, M.D.
George J. B. Stevens.
John F. Woods, M.D.

AUDITORS.

F. Gordon Brown.
Hope Grant.
William Rawes.
Thomas Glover Lyon, M.D.

LIBRARY COMMITTEE.

(*Appointed by the Council.*)

John W. Oliver, M.D.
R. Hingston Fox, M.D.
Fortescue Fox, M.D.
J. H. Sequeira, M.D.

ALTERATIONS IN RULES.

Former Rule.	As at present.
RULE 1.—The Society shall consist of Honorary, Corresponding, and Ordinary Fellows.	RULE 1.—The Society shall consist of Honorary, Corresponding and Ordinary Fellows, the Ordinary Fellows to be of two classes, Resident and Non-Resident respectively. (For a definition of Non-Resident Ordinary Fellow *vide* new rule 64.) Wherever in these rules the term "Fellows" alone or "Ordinary Fellows" is used it shall be understood to include both classes, unless the contrary be expressly stated.
RULE 61.—Every Ordinary Fellow shall pay a subscription of One Guinea annually. Annual subscriptions shall become due at Christmas and be paid in advance. Every Fellow, on admission, shall pay the subscription for the current year.	RULE 61.—Every Resident Ordinary Fellow shall pay a subscription of One Guinea annually. Annual Subscriptions shall become due on January the first of each year, and be paid in advance. Every Fellow on admission shall pay the subscription for the current year. (Fellows admitted in December must pay the subscription of One Guinea, but this is allowed to cover the following calendar year.)
RULE 62.—The sum of Ten Guineas paid on admission shall be a composition for annual payments. After fifteen annual subscriptions have been paid, the sum of Five Guineas shall be a composition for further annual payments.	RULE 62.—*The sum of Twelve Guineas* paid on admission shall be a composition for annual payments by **Resident Ordinary Fellows.** After fifteen annual subscriptions have been paid, the sum of Five Guineas shall be a composition for further annual payments by Resident Ordinary Fellows.
RULES 64, etc., to the end to be renumbered, owing to the addition of the new rules opposite.	RULE 64.—*"Ordinary" Fellows residing ten miles or more from the General Post Office of London, St. Martin Le Grand, shall be deemed Non-Resident, and shall pay an annual subscription of Half-a-Guinea. They shall be entitled to receive annually a copy of the Translations of the Society, and also any other publications of the Society which are sent to Ordinary Fellows.* *N.B.—Instead of Half-a-Guinea annually a Non-Resident Ordinary Fellow may, at his option, pay One Guinea every two years.*
	RULE 65. — *Non-Resident Ordinary Fellows shall be entitled to compound for annual payments under the same circumstances as Resident Ordinary Fellows, by payment of one half the sums payable by Resident Ordinary Fellows.*

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